MEMBER HANDBOOK

EFFECTIVE JULY 2008

NAVIGATOR by TUFTS Health Plan

Commonwealth of Massachusetts
Group Insurance Commission

Introduction

Welcome to Navigator by *Tufts Health Plan*™ ("Navigator"). We are pleased you have chosen this preferred provider organization (PPO) health plan. We look forward to working with you to help you meet your health care needs. This *Member Handbook* describes the **Navigator** health care plan. **Please note that italicized words in this document have special meanings. These meanings are given in the "Definitions" section (see Part 9, pages 75-82).**

Navigator is a self-funded plan, which means that the *Group Insurance Commission* (also referred to as "the *GIC"* or "Commission") is responsible for the cost of the *Covered Services* you receive under it. The *GIC* has contracted with *Tufts Health Plan*. Through *Tufts Health Plan,* Navigator offers you access to a network of health care professionals known as Tufts Health Plan ("Tufts HP") Providers and *Tufts HP* performs certain services, such as claims processing. *Tufts Health Plan* does not, however, insure plan benefits or determine your eligibility for benefits under the Navigator Plan.

This is a PPO plan and you are not required to designate a primary care physician (PCP) and you are not required to get a referral for specialty services. This *Member Handbook* will help you find answers to your questions about your PPO benefits.

Navigator *Members* have benefits for *Covered Services* according to the terms of this *Member Handbook*. The Plan covers your medical and prescription drug benefits. Your EAP/Mental Health and Substance Abuse benefits are included in this plan, but administered by United Behavioral Health (UBH).

Medical and Prescription Drug Plan - *Tufts Health Plan* administers Navigator, which provides the medical and prescription drug benefits described in this *Member Handbook.* Navigator *Members* are encouraged to receive medical services and prescription drugs from the *Tufts Health Plan* network of health care *Providers*. Using these *Tufts HP Providers* will minimize your out-of-pocket expenses for *Covered Services*. To find out which *Providers* are in the network, you can either:

- look in the Navigator *Directory of Health Care Providers*;
- call the Member Services Department at 1-800-870-9488; or
- check out the web site at **www.tuftshealthplan.com/gic**.

For ***Outpatient*** **medical care**, *Covered Services* provided by a *Tufts Health Plan Provider* are covered at the *In-Network Level of Benefits*. At the *In-Network Level of Benefits,* your Office Visit *Copayment* will vary depending on the type of physician who provides your care:

- Office visits to *PCPs*, *PCPs* who are specialists, and pediatricians are subject to a **$15** *Copayment*.
- Massachusetts *Tufts HP Providers* who are specialists in the following 12 specialties have been rated based on quality and cost-efficiency standards and then placed into three tiers (for more information about the standards used for placing these specialists into tiers, check out the web site at **www.tuftshealthplan.com/gic**). These specialties are cardiology; dermatology; endocrinology; gastroenterology; general surgery; neurology; obstetrics/gynecology; ophthalmology; orthopedics; otolaryngology; rheumatology; and urology. The *Copayments* at these three tiers apply as follows to these *Providers*:
  - *Copayment Tier 1 Specialist*: ★★★ Excellent – subject to **$15** *Copayment* per office visit
  - *Copayment Tier 2 Specialist*: ★★Good – subject to **$25** *Copayment* per office visit
  - *Copayment Tier 3 Specialist*: ★Standard – subject to **$35** *Copayment* per office visit
- Office visits to all other specialists are subject to a **$25** *Copayment*:
  - specialists outside of Massachusetts;
  - specialists in specialties not rated by *Tufts Health Plan*; and
  - specialists with insufficient date to evaluate.

Medical and Prescription Drug Plan (continued) –

***Inpatient* hospital stays** at *Tufts Health Plan Hospitals* for *Obstetric Services, Pediatric Services,* or *Adult Medical and Surgical Services* are grouped into *Inpatient* Hospital *Copayment* Levels based on the quality-cost score each hospital receives for each of these types of services (see Part 11, pages 89-93, for more information about the standards used for grouping the hospitals).

- Hospitals with an **excellent** quality and efficiency rating are grouped in *Inpatient Copayment* Tier 1 and require a **$200** *Copayment* per admission.
- Hospitals with a **good** quality and efficiency rating are grouped in *Inpatient Copayment* Tier 2 and require a **$400** *Copayment* per admission.

Please see "Benefit Overview" (page 10) and "Plan and Benefit Information" (page 22-23) for further details on your coverage and costs for medical services under this Plan. *Covered Services* that are not provided by a *Tufts HP Provider* are covered at the *Out-of-Network Level of Benefits* (see pages 23-25).

Prescription drug benefits that are available and the requirements that each *Member* needs to follow in order to obtain these benefits are described in Part 5 (see pages 39-63).

The Member Services Department is committed to excellent service. Your satisfaction with Navigator is important to us. If at any time you have questions, please call the Member Services Department which will be happy to help you. Calls to the Member Services Department may be monitored by supervisors to assure quality service.

EAP/Mental Health and Substance Abuse Plan – This plan is administered by United Behavioral Health (UBH). You and your covered family *Members* are automatically eligible for a full range of confidential and professional Enrollee Assistance Program (EAP), mental health and substance abuse services that are administered by UBH. Legal, family mediation and financial counseling services, grief counseling, and referrals to self-help groups and child or elder care services are among the many services available through the UBH EAP. For mental health or substance abuse services or in an emergency, UBH can help you access a conveniently located network Provider. UBH benefit information is located on pages [94-108] of this booklet.

Member Identification Card

Members must present their member identification card (member ID card) to *Providers* when they receive *Covered Services* in order for benefits to be administered properly. Each member ID card contains the following information:

- The amounts you must pay for certain *Covered Services* under the Navigator Plan (for example, your *Copayments* for *Emergency* room visits or for *In-Network* office visits);
- the toll-free *Tufts Health Plan* telephone number to call if you have questions about your medical and prescription drug coverage under the Navigator Plan; and
- the toll-free *United Behavioral Health* telephone number to call if you have questions related to the EAP/Mental Health and Substance Abuse coverage under this plan.

Tufts Health Plan Address And Telephone Directory

TUFTS HEALTH PLAN
705 Mount Auburn Street
Watertown, Massachusetts 02472-1508
Hours: Monday – Thursday 8:00 a.m. to 7:00 p.m. E.S.T.
Friday 8:00 a.m. to 5:00 p.m. E.S.T.

IMPORTANT PHONE NUMBERS:

***Emergency* Care**
If you are experiencing an *Emergency*, you should seek care at the nearest *Emergency* facility. If needed, call 911 for emergency medical assistance. If 911 services are not available in your area, call the local number for emergency medical services.

If you have an urgent medical need and cannot reach your physician, you should seek care at the nearest emergency room.

Liability Recovery
Call the Liability and Recovery Department at 1-888-880-8699, extension 1098 for questions about coordination of benefits and workers' compensation. For example, call the Liability and Recovery Department if you have any questions about how *Tufts Health Plan* (*Tufts HP*) coordinates coverage with other health care coverage that you may have. The Liability and Recovery Department is available from 8:30 a.m. – 5:00 p.m. Monday through Thursday and from 10:00 – 5:00 p.m. on Friday.

For questions related to subrogation (when someone else's fault caused your illness or injury, such as injuries from an auto accident), call the Member Services Department at 1-800-870-9488.

Member Services Department
Call the Member Services Department at 1-800-870-9488 for general questions, benefit questions, and information regarding eligibility for enrollment and billing.

Services for Hearing Impaired *Members*
If you are hearing impaired, the following services are provided:

Massachusetts Relay (MassRelay) 1-800-720-3480

Telecommunications Device for the Deaf (TDD)

If you have access to a TDD phone, call 1-800-868-5850 to reach the Member Services Department.

IMPORTANT ADDRESSES:

Appeals and Grievances Department
If you need to call *Tufts HP* about a concern or appeal, contact the Member Services Department at 1-800-870-9488. To submit your appeal or grievance in writing, send your letter to:

Tufts Health Plan
Attn: Appeals and Grievances Department
705 Mount Auburn Street
P.O. Box 9193
Watertown, MA 02471-9193

Web site
For more information about *Tufts Health Plan* and to learn more about the self-service options that are available to you, please see the *Tufts Health Plan* Web site at **www.tuftshealthplan.com**.

Translating Services

Translating services for 140 languages
Interpreter and translator services related to administrative procedures are available to assist *Members* upon request. For information, please call the Member Services Department.

خدمات المترجمين والترجمة المتعلقة بالإجراءات الإدارية متوفرة لمساعدتك في هذا الشأن. لطلب هذه الخدمات، الرجاء الاتصال بقسم علاقات الزبون التابع لخطة "تفتس هلس بلان".

អ្នកបកប្រែភាសា និងកិច្ចការបកប្រែទាំងឡាយ ដែលជាប់ទាក់ទងនឹងទំរង់ការខាងការចាត់ចែងការ គឺមានផ្តល់សំរាប់ជួយអ្នក ។ ដើម្បីស្នើសុំការបំរើទាំងនេះ សូមទូរស័ព្ទមកក្រសួងទំនាក់ទំនងភ្ញៀវ នៃគំរោងថែរក្សាសុខភាពរបស់ Tufts ។

相關管理程序的口譯和筆譯服務隨時爲您提供協助。如需要這些服務，請打電話給「Tufts 健康計劃顧客聯絡部」。

Des services d'interprétariat et de traduction liés aux procédures administratives sont disponibles. Pour demander ces services, veuillez contacter le département des relations avec la clientèle de Tufts Health Plan.

Για την εξυπηρέτησή σας, υπάρχουν διαθέσιμες υπηρεσίες ερμηνείας και μετάφρασης σχετικά με τις διοικητικές διαδικασίες. Για να ζητήσετε αυτές τις υπηρεσίες, τηλεφωνήστε στο Τμήμα Πελατειακών Σχέσεων του Προγράμματος Ιατροφαρμακευτικής Ασφάλισης Tufts.

ພວກເຮົາມີບໍລິການນາຍພາສາແລະການແປເອກະສານທາງດ້ານວິທີດຳເນີນການທຸລະກາມໄວ້ ບໍລິການທ່ານ. ກະລຸນາໂທຫາພະແນກບໍລິການລູກຄ້າຂອງແຜນສຸຂະພາບທັຟສ Tufts , ຖ້າຕ້ອງການບໍລິການເຫລົ່ານີ້.

Temos disponíveis serviços de tradução e interpretação relacionados aos procedimentos administrativos. Para obter estes serviços, ligue para o departamento de relações com o cliente do Tufts Health Plan.

С целью оказать Вам помощь по административным процедурам предлагаются устные и письменные переводческие услуги. Если Вам нужны эти услуги, позвоните, пожалуйста, в Отдел связей с клиентами Плана здравоохранения «Тафтс» Tufts.

Los servicios de traducción e interpretación en relación a procedimientos administrativos están disponibles para ayudarle. Para solicitar este servicio, favor de llamar al departamento de relaciones con el cliente de Tufts Health Plan.

Genyen sèvis tradiksyon ak entèprèt disponib pou ede ou nan zafè ki gen rapò ak jan administrasyon an fè sèvis li. Pou ou mande sèvis sa yo, tanpri rele depatman sèvis kliyan Tufts Health Plan.

1-800-870-9488

TDD Telecommunications Device for the Deaf: 1-800-868-5850

Table of Contents

Table of Contents, Continued

MEDICAL AND PRESCRIPTION DRUG PLAN, continued

Part 5 – *Covered Services*, continued

Table of Contents, Continued

MEDICAL AND PRESCRIPTION DRUG PLAN, continued

Part 5 – *Covered Services*, continued

Table of Contents, Continued

MEDICAL AND PRESCRIPTION DRUG PLAN, continued

NAVIGATOR

by TUFTS Health Plan

Medical and Prescription Drug Benefits

Part 1 - Benefit Overview

Do not rely on this chart alone. It merely summarizes certain important benefits available to Navigator *Members*. **Be sure to read the benefit explanations in Part 5 (see pages 39-63)**. They describe *Covered Services* in more detail and contain some important restrictions. Remember, in order to receive In-Network *Covered Services*, you must receive care from a *Tufts HP Provider*.

Deductibles and Maximums

	In-Network	*Out-of-Network*
	***Member's* Cost**	***Member's* Cost**
***Day Surgery Copayment* Maximum (*In-Network Level of Benefits* only)** ☞ Page 23	Four *Day Surgery Copayments* of $100 per *Member* apply for each individual *Member* per *calendar year*. Once the *Day Surgery Copayment* Maximum is reached in a *calendar year*, *Member* is not responsible for any additional *Day Surgery Copayments* for the remainder of the year.	Not applicable.
***Inpatient* Care *Copayment* Maximum (*In-Network Level of Benefits* only)** ☞ Page 23	Four *Inpatient Copayments* apply for each individual *Member* per *calendar year*. Once this *Inpatient Copayment* Maximum is reached in a *calendar year*, the *Member* is not responsible for any additional *Inpatient Copayments* for the remainder of the *calendar year*. *Members* will only be responsible for one *Copayment* if readmitted within 30 days of discharge in the same *calendar year*. Please call Member Services.	Not applicable.
***Deductible*:** ☞ Page 24	None	$150 per *Member* each *calendar year*. (Each of two *Members* must satisfy a *Member Deductible* per *Family Plan*.)
***Out-of-Network Out-of-Pocket Maximum*:** ☞ Page 25	Not applicable	$3,000 per *Member* each *calendar year*. (*Deductible* counts toward this *Out-of-Pocket Maximum*)

Covered Services	*In-Network Level of Benefits*	*Out-of-Network Level of Benefits**
	***Member's* Cost**	***Member's* Cost**
Emergency Care		
•Treatment in an *Emergency* room ☞ Page 40	$50 *Copayment* (waived if admitted as an *Inpatient*)	$50 *Copayment* (waived if admitted as an *Inpatient*)
•Treatment for an *Emergency* in a physician's office ☞ Page 40	**$15 *Copayment*** when care provided by a *Tufts HP Provider who is a Primary Care Physician ("PCP")* or, a *PCP/*Specialist, or a pediatrician. **$15 *Copayment*** when care provided by *Tufts HP Provider* who is a *Copayment Tier 1 Specialist*. **$25 *Copayment*** when care provided by *Tufts HP Provider* who is a *Copayment Tier 2 Specialist.* **$35 *Copayment*** when care provided by *Tufts HP Provider* who is a *Copayment Tier 3 Specialist.* **$25 *Copayment*** when care is provided by any other *Tufts HP Provider* who is a specialist.	**$15 *Copayment*** when care provided by non-*Tufts HP Provider* who is a *PCP.* **$25 *Copayment*** when care is provided by a non-*Tufts HP Provider* who is a specialist.

***A *Member* must call *Tufts Health Plan* at 1-800-870-9488 within 48 hours after he or she is admitted as an *Inpatient* after *Emergency* Care is received in order to be covered at the *In-Network Level of Benefits*.**

Outpatient Care – Office Visit *Copayments*

Important Note: If you receive *Outpatient* care at an office visit with a *Tufts HP Provider*, your Office Visit *Copayment* will vary depending on the type of physician who provides your care:

- Office visits to *Primary Care Physicians ("PCPs")*, *PCPs* who are specialists**,** or pediatricians are subject to a **$15** *Copayment*.
- Massachusetts *Tufts HP Providers* who are specialists in the following 12 specialties have been rated based on quality and cost-efficiency standards and then placed into three tiers (for more information about the standards used for placing these specialists into tiers, check out the web site at **www.tuftshealthplan.com/gic**). These specialties are cardiology; dermatology; endocrinology; gastroenterology; general surgery; neurology; obstetrics/gynecology; ophthalmology; orthopedics; otolaryngology; rheumatology; and urology. The *Copayments* at these three tiers apply as follows to these *Providers*:
  - *Copayment Tier 1 Specialist*: ★★★ Excellent – subject to **$15** *Copayment* per office visit
  - *Copayment Tier 2 Specialist*: ★★Good – subject to **$25** *Copayment* per office visit
  - *Copayment Tier 3 Specialist*: ★Standard – subject to **$35** *Copayment* per office visit
- Office visits to all other *Tufts HP Providers* who are specialists are subject to a **$25** *Copayment* per office visit:
  - specialists outside of Massachusetts;
  - specialists in specialties not rated by *Tufts Health Plan*; and
  - specialists with insufficient date to evaluate.

For a list of *Tufts HP Providers* (including their Specialist Tiers*,* if applicable*),* please refer to the Web site at **www.tuftshealthplan.com/gic,** to the Provider Directory, or to the Addendum of Tiered Network Specialists.

Covered Services	***In-Network Level of Benefits***	***Out-of-Network Level of Benefits***
	***Member's* Cost**	***Member's* Cost**
***Outpatient* Care**		
Cardiac rehabilitation ☞ Page 40	$15 *Copayment*	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)
Coronary Artery Disease Program ☞ Page 40	10% of the *Reasonable Charge*.	Full cost. This is not covered at the *Out-of-Network Level of Benefits*.
Diabetes self-management training and educational services ☞ Page 41	**$15 *Copayment*** when care provided by a *Tufts HP Provider who is a PCP, a PCP/*Specialist, or a pediatrician. **$15 *Copayment*** when care provided by a *Tufts HP Provider* who is *Copayment Tier 1 Specialist*. **$25 *Copayment*** when care provided by a *Tufts HP Provider* who is a *Copayment Tier 2 Specialist.* **$35 *Copayment*** when care provided by a *Tufts HP Provider* who is a *Copayment Tier 3 Specialist*. **$25 *Copayment*** when care is provided by any other *Tufts HP* Specialist.	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)
Early intervention services ☞ Page 41	**Covered up to a total of $5,200 per *Member* each *calendar year* ($15,600 lifetime) (*In-Network* and *Out-of Network Levels* combined)** $15 *Copayment*	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)
Family planning procedures, services, and contraceptives ☞ Page 41	Office Visit: **$15 *Copayment*** when care provided by a *Tufts HP Provider who is a PCP, a PCP/*Specialist, or a pediatrician. **$15 *Copayment*** when care provided by a *Tufts HP Provider* who is *Copayment Tier 1 Specialist*. **$25 *Copayment*** when care provided by a *Tufts HP Provider* who is a *Copayment Tier 2 Specialist.* **$35 *Copayment*** when care provided by a *Tufts HP Provider* who is a *Copayment Tier 3 Specialist*. **$25 *Copayment*** when care is provided by any other *Tufts HP* Specialist. *Day Surgery:* $100 *Copayment*** per person per *Day Surgery* admission, up to the *Day Surgery Copayment Maximum* described on page 23 above.	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)

**This *Copayment* also applies for *Covered Day Surgery* services at a free-standing surgical center.

(AR) – These services may require approval by an *Authorized Reviewer* prior to treatment for coverage at both the In-Network and Out-of-Network Levels of Benefits. When you receive care from a non-*Tufts HP Provider*, you are responsible for obtaining this prior approval from an *Authorized Reviewer*. If prior approval is not received, the Navigator Plan will not cover those services and supplies. For more information, call Member Services.

Covered Services	***In-Network Level of Benefits***	***Out-of-Network Level of Benefits***
	***Member's* Cost**	***Member's* Cost**
***Outpatient* Care, continued:**		
***Outpatient* medical care**		
Hemodialysis ☞ Page 41	Covered in full.	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)
Infertility services (including up to five attempted ART procedures) **(AR)** ☞ Page 42	Office Visit: **$$15 *Copayment*** when care provided by a *Tufts HP Provider who is a PCP, a PCP*/Specialist, or a pediatrician. **$15 *Copayment*** when care provided by a *Tufts HP Provider* who is *Copayment Tier 1 Specialist*. **$25 *Copayment*** when care provided by a *Tufts HP Provider* who is a *Copayment Tier 2 Specialist.* **$35 *Copayment*** when care provided by a *Tufts HP Provider* who is a *Copayment Tier 3 Specialist*. **$25 *Copayment*** when care is provided by any other *Tufts HP* Specialist. All other services: Covered in full.	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)
Maternity care (includes prenatal & postpartum care) ☞ Page 43	Covered in full.	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)
Allergy testing ☞ Page 43	**$15 *Copayment*** when care provided by a *Tufts HP Provider who is a PCP, a PCP*/Specialist, or a pediatrician. **$15 *Copayment*** when care provided by a *Tufts HP Provider* who is *Copayment Tier 1 Specialist*. **$25 *Copayment*** when care provided by a *Tufts HP Provider* who is a *Copayment Tier 2 Specialist.* **$35 *Copayment*** when care provided by a *Tufts HP Provider* who is a *Copayment Tier 3 Specialist*. **$25 *Copayment*** when care is provided by any other *Tufts HP* Specialist.	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)
Chemotherapy ☞ Page 43	Covered in full.	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)
Chiropractic care ☞ See "Spinal Manipulation"		
Cytology examinations (Pap Smears) - one annual screening ☞ Page 43	Covered in full.	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)

**This *Copayment* also applies for *Covered Day Surgery* services at a free-standing surgical center.

(AR) – These services may require approval by an *Authorized Reviewer* prior to treatment for coverage at both the *In-Network* and *Out-of-Network Levels of Benefits*. When you receive care from a non-*Tufts HP Provider*, you are responsible for obtaining this prior approval from an *Authorized Reviewer*. If prior approval is not received, the Navigator Plan will not cover those services and supplies. For more information, call Member Services.

Part 1 - Benefit Overview, Continued

Covered Services	*In-Network Level of Benefits*	*Out-of-Network Level of Benefits*
	***Member's* Cost**	***Member's* Cost**
***Outpatient* Care, continued:**		
***Outpatient* medical care, continued**		
Diagnostic screening procedures (for example, colonoscopies, endoscopies, sigmoidoscopies, and proctosigmoidoscopies) ☞ Page 43	**Diagnostic screening procedure only (for example, a colonoscopy):** Covered in full. **Diagnostic screening procedure accompanied by treatment/surgery (for example, a colonoscopy accompanied by polyp removal):** $100 *Copayment*** per person per *Day Surgery* admission, up to the *Day Surgery Copayment* Maximum described on page 23 below.	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)
Diagnostic imaging • General imaging (such as x-rays and ultrasounds) • MRI/MRA, CT/CTA, PET and nuclear cardiology **(AR)** ☞ Page 43	General imaging: Covered in full. MRI/MRA, CT/CTA, PET and nuclear cardiology: Covered in full.	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)
Human leukocyte antigen testing ☞ Page 43	Covered in full.	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)
Laboratory tests **(AR)** ☞ Page 43	Covered in full.	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)
Mammograms ☞ Page 43	Covered in full.	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)
Medically Necessary diagnosis and treatment of speech, hearing and language disorders (includes speech therapy) **(AR)** ☞ Page 43	Covered in full.	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)
Neuropsychological testing for a medical condition **(AR)** ☞ Page 43	Covered in full.	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)
Nutritional counseling ☞ Page 43	**$15 *Copayment*** when care provided by a *Tufts HP Provider* who is a *PCP*, a *Copayment Tier 1 Specialist*, or a nutritionist. **$25 *Copayment*** when care provided by a *Tufts HP Provider* who is a *Copayment Tier 2 Specialist*. **$35 *Copayment*** when care provided by a *Tufts HP Provider* who is a *Copayment Tier 3 Specialist*.	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)

**This *Copayment* also applies for *Covered Day Surgery* services at a free-standing surgical center.

(AR) – These services may require approval by an *Authorized Reviewer* prior to treatment for coverage at both the In-Network and Out-of-Network Levels of Benefits. When you receive care from a non-*Tufts HP Provider*, you are responsible for obtaining this prior approval from an *Authorized Reviewer*. If prior approval is not received, the Navigator Plan will not cover those services and supplies. For more information, call Member Services.

Covered Services	***In-Network Level of Benefits***	***Out-of-Network Level of Benefits***
	***Member's* Cost**	***Member's* Cost**
***Outpatient* Care, continued:**		
***Outpatient* medical care, continued**		
Office visits ☞ Page 44	**$15 *Copayment*** when care provided by a *Tufts HP Provider who is a PCP, a PCP*/Specialist, or a pediatrician. **$15 *Copayment*** when care provided by a *Tufts HP Provider* who is *Copayment Tier 1 Specialist*. **$25 *Copayment*** when care provided by a *Tufts HP Provider* who is a *Copayment Tier 2 Specialist.* **$35 *Copayment*** when care provided by a *Tufts HP Provider* who is a *Copayment Tier 3 Specialist*. **$25 *Copayment*** when care is provided by any other *Tufts HP* Specialist.	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)
Outpatient surgery in a physician's office ☞ Page 44	**$15 *Copayment*** when care provided by a *Tufts HP Provider who is a PCP, a PCP*/Specialist, or a pediatrician. **$15 *Copayment*** when care provided by a *Tufts HP Provider* who is *Copayment Tier 1 Specialist*. **$25 *Copayment*** when care provided by a *Tufts HP Provider* who is a *Copayment Tier 2 Specialist.* **$35 *Copayment*** when care provided by a *Tufts HP Provider* who is a *Copayment Tier 3 Specialist*. **$25 *Copayment*** when care is provided by any other *Tufts HP* Specialist.	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)
Radiation therapy andx-ray therapy ☞ Page 44	Covered in full.	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)
Voluntary second or third surgical opinions ☞ Page 44	**$15 *Copayment*** when care provided by a *Tufts HP Provider who is a PCP, a PCP*/Specialist, or a pediatrician. **$15 *Copayment*** when care provided by a *Tufts HP Provider* who is *Copayment Tier 1 Specialist*. **$25 *Copayment*** when care provided by a *Tufts HP Provider* who is a *Copayment Tier 2 Specialist.* **$35 *Copayment*** when care provided by a *Tufts HP Provider* who is a *Copayment Tier 3 Specialist*. **$25 *Copayment*** when care is provided by any other *Tufts HP* Specialist.	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)

(AR) – These services may require approval by an *Authorized Reviewer* prior to treatment for coverage at both the In-Network and Out-of-Network Levels of Benefits. When you receive care from a non-*Tufts HP Provider*, you are responsible for obtaining this prior approval from an *Authorized Reviewer*. If prior approval is not received, the Navigator Plan will not cover those services and supplies. For more information, call Member Services.

Covered Services	***In-Network Level of Benefits***	***Out-of-Network Level of Benefits***
	***Member's* Cost**	***Member's* Cost**
***Outpatient* Care, continued:**		
***Outpatient* medical care, continued**		
Patient care services provided as part of a qualified clinical trial (for treatment of cancer) ☞ Page 44	**$15 *Copayment*** when care provided by a *Tufts HP Provider who is a PCP, a PCP/*Specialist, or a pediatrician. **$15 *Copayment*** when care provided by a *Tufts HP Provider* who is *Copayment Tier 1 Specialist*. **$25 *Copayment*** when care provided by a *Tufts HP Provider* who is a *Copayment Tier 2 Specialist.* **$35 *Copayment*** when care provided by a *Tufts HP Provider* who is a *Copayment Tier 3 Specialist*. **$25 *Copayment*** when care is provided by any other *Tufts HP* Specialist.	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)
Preventive health care - Adults (age 18 and over) (includes hearing exams) ☞ Page 44	**$15 *Copayment*** when care provided by a *Tufts HP Provider who is a PCP, a PCP/*Specialist, or a pediatrician. **$15 *Copayment*** when care provided by a *Tufts HP Provider* who is *Copayment Tier 1 Specialist*. **$25 *Copayment*** when care provided by a *Tufts HP Provider* who is a *Copayment Tier 2 Specialist.* **$35 *Copayment*** when care provided by a *Tufts HP Provider* who is a *Copayment Tier 3 Specialist*. **$25 *Copayment*** when care is provided by any other *Tufts HP* Specialist.	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)

(AR) – These services may require approval by an *Authorized Reviewer* prior to treatment for coverage at both the In-Network and Out-of-Network Levels of Benefits. When you receive care from a non-*Tufts HP Provider*, you are responsible for obtaining this prior approval from an *Authorized Reviewer*. If prior approval is not received, the Navigator Plan will not cover those services and supplies. For more information, call Member Services.

Covered Services	*In-Network Level of Benefits*	*Out-of-Network Level of Benefits*
	***Member's* Cost**	***Member's* Cost**
***Outpatient* Care, continued:**		
***Outpatient* medical care, continued**		
Preventive health care - *Children* (under age 18) ☞ Page 44	**$15 *Copayment*** when care provided by a *Tufts HP Provider who is a PCP, a PCP/*Specialist, or a pediatrician. **$15 *Copayment*** when care provided by a *Tufts HP Provider* who is *Copayment Tier 1 Specialist*. **$25 *Copayment*** when care provided by a *Tufts HP Provider* who is a *Copayment Tier 2 Specialist.* **$35 *Copayment*** when care provided by a *Tufts HP Provider* who is a *Copayment Tier 3 Specialist*. **$25 *Copayment*** when care is provided by any other *Tufts HP* Specialist.	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)
Routine annual gynecological exam ☞ Page 44	**$15 *Copayment*** when care provided by a *Tufts HP Provider who is a PCP* or *a PCP/*Specialist. **$15 *Copayment*** when care provided by a *Tufts HP Provider* who is *Copayment Tier 1 Specialist*. **$25 *Copayment*** when care provided by a *Tufts HP Provider* who is a *Copayment Tier 2 Specialist.* **$35 *Copayment*** when care provided by a *Tufts HP Provider* who is a *Copayment Tier 3 Specialist*.	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)
Short-term physical & occupational therapy services **(AR)** ☞ Page 45	$15 *Copayment*	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)
Vision care services		
• Routine eye exam (see page 45 for more information about this benefit and its limits) ☞ Page 45	$15 *Copayment* applies. Please note that services must be received from an EyeMed network provider.	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)
• Other vision care services ☞ Page 45	**$15 *Copayment*** when care provided by a *Tufts HP Provider who is a PCP, a PCP/*Specialist, or a pediatrician. **$15 *Copayment*** when care provided by a *Tufts HP Provider* who is *Copayment Tier 1 Specialist*. **$25 *Copayment*** when care provided by a *Tufts HP Provider* who is a *Copayment Tier 2 Specialist.* **$35 *Copayment*** when care provided by a *Tufts HP Provider* who is a *Copayment Tier 3 Specialist*. **$25 *Copayment*** when care is provided by any other *Tufts HP* Specialist.	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)

(AR) – These services may require approval by an *Authorized Reviewer* prior to treatment for coverage at both the *In-Network* and *Out-of-Network Levels of Benefits*. When you receive care from a non-*Tufts HP Provider*, you are responsible for obtaining this prior approval from an *Authorized Reviewer*. If prior approval is not received, the Navigator Plan will not cover those services and supplies. For more information, call Member Services.

Covered Services	*In-Network Level of Benefits*	*Out-of-Network Level of Benefits*
	***Member's* Cost**	***Member's* Cost**
Oral health services		
Emergency care ☞ Page 45	Treatment in an *Emergency* room: $50 *Copayment* (waived if admitted as an *Inpatient*). Treatment in a physician's office: **$15 *Copayment*** when care provided by a *Tufts HP Provider who is a PCP, a PCP/*Specialist, or a pediatrician. **$15 *Copayment*** when care provided by a *Tufts HP Provider* who is *Copayment Tier 1 Specialist*. **$25 *Copayment*** when care provided by a *Tufts HP Provider* who is a *Copayment Tier 2 Specialist.* **$35 *Copayment*** when care provided by a *Tufts HP Provider* who is a *Copayment Tier 3 Specialist*. **$25 *Copayment*** when care is provided by any other *Tufts HP* Specialist.	Treatment in an *Emergency* room: $50 *Copayment* (waived if admitted as an *Inpatient*). Treatment in a physician's office: $25 *Copayment*.
Oral surgery for dental treatment **(AR)** ☞ Page 45	*Day Surgery*: $100 *Copayment*** per person per *Day Surgery* admission, up to the *Day Surgery Copayment* Maximum described below. *Inpatient* care: Applicable *Inpatient* care *Copayment* (see "*Inpatient* Care" below).	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)
Oral surgical procedures for non-dental medical treatment **(AR)** ☞ Page 45	Office visit: **$15 *Copayment*** when care provided by a *Tufts HP Provider who is a PCP, a PCP/*Specialist, or a pediatrician. **$15 *Copayment*** when care provided by a *Tufts HP Provider* who is *Copayment Tier 1 Specialist*. **$25 *Copayment*** when care provided by a *Tufts HP Provider* who is a *Copayment Tier 2 Specialist.* **$35 *Copayment*** when care provided by a *Tufts HP Provider* who is a *Copayment Tier 3 Specialist*. **$25 *Copayment*** when care is provided by any other *Tufts HP* Specialist. *Day Surgery*: $100 *Copayment*** per person per *Day Surgery* admission, up to the *Day Surgery Copayment* Maximum described below. *Inpatient* care: Applicable *Inpatient* care *Copayment* (see "*Inpatient* Care" below).	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)

**This *Copayment* also applies for *Covered Day Surgery* services at a free-standing surgical center.

(AR) – These services may require approval by an *Authorized Reviewer* prior to treatment for coverage at both the *In-Network* and *Out-of-Network Levels of Benefits*. When you receive care from a non-*Tufts HP Provider*, you are responsible for obtaining this prior approval from an *Authorized Reviewer*. If prior approval is not received, the Navigator Plan will not cover those services and supplies. For more information, call Member Services.

Covered Services	***In-Network Level of Benefits***	***Out-of-Network Level of Benefits****
	***Member's* Cost**	***Member's* Cost**
***Day Surgery*:**		
Day Surgery **(AR)** ☞ Page 46	$100 *Copayment*** per person per *Day Surgery* admission, up to the *Day Surgery Copayment* Maximum described on page 23.	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)
***Inpatient* Care:**		
Acute hospital services (including room and board, physician services, surgery, and related services) **(AR)** ☞ Page 46	***INPATIENT COPAYMENT TIERS*:** *Inpatient Copayment Tier 1* ($200) or *Inpatient Copayment Tier 2* ($400) for *Inpatient Obstetric Services, Pediatric Services, or Adult Medical and Surgical Services* up to the *Inpatient* Care *Copayment* Maximum described on page 23. See Part 11 on pages 89-93 for the Navigator *Inpatient* Hospital *Copayment Tiers* and for information on *Inpatient Copayments* for newborn *Children*.	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)
Bone Marrow Transplants for Breast Cancer, Hematopoietic Stem Cell Transplants, and Human Solid Organ Transplants **(AR)** ☞ Page 47		*Deductible* & 20% of the *Reasonable Charge* (plus any balance)
Maternity care (Hospital and delivery services are subject to the *Inpatient Obstetric Services Copayment* at the *In-Network Level of Benefits*) ☞ Page 48		*Deductible* & 20% of the *Reasonable Charge* (plus any balance)
Patient care services provided as part of a qualified clinical trial (for treatment of cancer) ☞ Page 49		*Deductible* & 20% of the *Reasonable Charge* (plus any balance)
Reconstructive surgery and procedures **(AR)** ☞ Page 49		*Deductible* & 20% of the *Reasonable Charge* (plus any balance)

***The *Member* is required to *preregister* any *Out-of-Network* hospital admission, or must pay a $500 Preregistration Penalty for that admission.**

**This *Copayment* also applies for *Covered Day Surgery* services at a free-standing surgical center.

(AR) – These services may require approval by an *Authorized Reviewer* prior to treatment for coverage at both the *In-Network* and *Out-of-Network Levels of Benefits*. When you receive care from a non-*Tufts HP Provider*, you are responsible for obtaining this prior approval from an *Authorized Reviewer*. If prior approval is not received, the Navigator Plan will not cover those services and supplies. For more information, call Member Services.

Covered Services	***In-Network Level of Benefits***	***Out-of-Network Level of Benefits***
	***Member's* Cost**	***Member's* Cost**
Other Health Services:		
Ambulance services **(AR)** ☞ Page 50	Covered in full.	Covered in full.
Extended care facility services in: **(AR)** ▪skilled nursing facility; ▪rehabilitation hospital; or ▪chronic hospital. ☞ Page 50	Extended care facility services in a skilled nursing facility*: 20% of the *Reasonable Charge.* Extended care facility services in a rehabilitation hospital or chronic hospital: Covered in full.	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)
	Covered facility and physician services in a skilled nursing facility are limited to 45 days per *Member* per *calendar year* (*In-Network* and *Out-of-Network Levels* combined).** • **The cost of services provided in a skilled nursing facility at the *Out-of-Network Level of Benefits* cannot be used to satisfy the *Member's Out-of-Network Out-of-Pocket Maximum. **•Preregistration is required prior to any *Out-of-Network* admission, or the *Member* must pay a $500 Preregistration Penalty (see pages 32- 34).**	
Home health care **(AR)** ☞ Page 51	Covered in full.	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)
	All home health care treatment plans must be authorized by an *Authorized Reviewer*.	
Hospice care ☞ Page 51	Covered in full.	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)
Injectable medications **(AR)** ☞ Page 52	Covered in full.	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)
Medical appliances and equipment: ▪*Durable Medical Equipment* (including *Prosthetic Devices*) **(AR)** ☞ Page 52	Covered in full.	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)
▪Eyeglasses/contact Lenses (only the first pair after cataract surgery) ☞ Page 53	Covered in full.	20% of the *Reasonable Charge* (not subject to the *Deductible*)
▪Hearing aids ☞ Page 53	**The first $500 is covered in full. Then, 20% of the next $1,500 (plus any balance) (*In-Network* and *Out-of-Network Levels* combined).** **Maximum benefit of $1,700 per *Member* in each 24-month period (*In-Network* and *Out-of-Network Levels* combined).**	

(AR) – These services may require approval by an *Authorized Reviewer* prior to treatment for coverage at both the *In-Network* and *Out-of-Network Levels of Benefits*. When you receive care from a non-*Tufts HP Provider*, you are responsible for obtaining this prior approval from an *Authorized Reviewer*. If prior approval is not received, the Navigator Plan will not cover those services and supplies. For more information, call Member Services.

Covered Services	*In-Network Level of Benefits*	*Out-of-Network Level of Benefits*
	***Member's* Cost**	***Member's* Cost**
Other Health Services, continued:		
Personal Emergency Response System (only hospital-based) ☞ Page 54	Coverage is provided for a Personal Emergency Response System up to $50 for installation and up to $40 per month for rental fees. The Navigator Plan pays 80% of the charges up to these maximum allowed installation and rental charges. You are responsible for paying the remaining 20% of those charges, as well as any additional fees or charges for the system.	
Private duty nursing care (*Inpatient* and *Outpatient*) **(AR)** ☞ Page 54	Covered in full.	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)
	Covered up to a total of $8,000 per *Member* in a *calendar year* (*In-Network* and *Out-of-Network Levels* combined).	
Scalp hair prostheses or wigs for cancer or leukemia patients ☞ Page 54	Covered in full. **Covered up to a total of $350 per *Member* in a *calendar year* (*In-Network* and *Out-of-Network Levels* combined).**	Covered in full.
Special Medical Formulas		
Low protein foods ☞ Page 54	Covered in full. **Covered up to a total of $2,500 per *Member* in a *calendar year* (In-Network and Out-of-Network Levels combined).**	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)
Nonprescription enteral formulas **(AR)** ☞ Page 55	Covered in full.	Covered in full.
Special medical formulas **(AR)** ☞ Page 55	Covered in full.	Covered in full.
Spinal manipulation (chiropractic care) ☞ Page 55	$15 *Copayment*. **Limited to a total of one spinal manipulation evaluation and 20 visits per *calendar year* (*In-Network* and *Out-of-Network Levels* combined).**	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)

(AR) – These services may require approval by an *Authorized Reviewer* prior to treatment for coverage at both the *In-Network* and *Out-of-Network Levels of Benefits*. When you receive care from a non-*Tufts HP Provider*, you are responsible for obtaining this prior approval from an *Authorized Reviewer.* If prior approval is not received, the Navigator Plan will not cover those services and supplies. For more information, call Member Services.

Prescription Drug Benefit (see pages 56-60)

For information about your *Copayments* for covered prescription drugs, see the "Prescription Drug Benefit" section in Part 5.

EAP/Mental Health & Substance Abuse Services (see pages 94-108)

Benefits administered by United Behavioral Health. For information, call 1-888-610-9039.

Your Cost for Medical Services

You are responsible for paying the costs described below for *Covered Services* you receive at the *In-Network* and *Out-of-Network Levels of Benefits*. For more information about the *Covered Services* subject to these costs, please see Part 5.

In-Network Level of Benefits

Covered Services are covered at the *In-Network Level of Benefits* only when the *Covered Services* are provided by a *Tufts HP Provider*.

If a *Covered Service* is not available from a *Tufts HP Provider*, as determined by *Tufts Health Plan*, with *Tufts Health Plan's* approval you may receive *Covered Services* at the *In-Network Level of Benefits* from a non-*Tufts HP Provider* up to the *Reasonable Charge*. You will be responsible for any charges in excess of the *Reasonable Charge.*

Copayments

- *Emergency* Care:
  - *Emergency* room ..... $50 per visit.
  - In physician's office..... see page 11

  Notes:
  - An Emergency room *Copayment* may apply if you register in an emergency room but leave that facility without receiving care.
  - A *Day Surgery Copayment* may apply if *Day Surgery* services are received.

- *In-Network Level of Benefits*:
  - Office Visit..... see page 11

    Note: For certain *Outpatient* services listed as "covered in full" at the *In-Network Level of Benefits* in the Benefit Overview table (see pages 10-21), you may be charged an Office Visit *Copayment* when these services are provided in conjunction with an office visit.

  - *Inpatient* Services ..... Varies by service and hospital chosen; see Part 11.
  - *Day Surgery*..... $100 per admission.

In-Network Level of Benefits, continued

***Day Surgery Copayment* Maximum (*In-Network Level of Benefits* Only)**

Each individual *Member* is responsible for paying four *Day Surgery Copayments* per *calendar year*.

The *Day Surgery Copayment* Maximum is the most money you will have to pay for *Day Surgery* in a *calendar year*. This Maximum consists of *In-Network Day Surgery Copayment*s only. It does not include *Deductibles*, *Coinsurance*, other *Copayments*, or payments you make for non-*Covered Services* or *Out-of-Network* care. When the *Copayment* Maximum is reached, no more *Day Surgery Copayments* will be charged in that *calendar year*.

***Inpatient* Care *Copayment* Maximum (*In-Network Level of Benefits* Only)**

Each individual *Member* is responsible for paying a maximum of four *Inpatient Copayments* in a *calendar year*. This maximum consists of in-network *Inpatient* care *Copayments* for *Pediatric Services, Inpatient Obstetric Services,* and/or *Inpatient Adult Medical Surgical Services*. You are responsible for only one *Copayment* for two separate *Inpatient* admissions if you are readmitted within 30 days of discharge after the first admission. Please note, though, that this rule does not apply to two *Inpatient* admissions in different *calendar years*.

The *Inpatient* Care *Copayment* Maximum is the most money you will have to pay for *Inpatient* care in a *calendar year*. This maximum consists of *In-Network Inpatient* care *Copayments* only. It does not include *Deductibles*, *Coinsurance*, other *Copayments*, or payments you make for non-*Covered Services*. Once this *Inpatient Copayment* Maximum is reached in a *calendar year*, the *Member* is not responsible for any additional *Inpatient Copayments* for the remainder of the *calendar year*.

Coinsurance

There is no *Coinsurance* for most *Covered Services* provided by a *Tufts HP Provider*. Except as shown in Part 1 (see "Benefit Overview" on pages 10-21), the *Member* pays the applicable *Copayment* for all *Covered Services* provided by a *Tufts HP Provider*. The *Plan* will cover the remaining charges for *Covered Services*.

Out-of-Network Level of Benefits

Covered Services are covered at the *Out-of-Network Level of Benefits* when you receive them from a non-*Tufts HP Provider*. These *Covered Services* are subject to a *Deductible* and *Coinsurance*, and are covered at a lower level than *Covered Services* provided at the *In-Network Level of Benefits*.

Notes:

- Each time you receive care at the *Out-of-Network Level of Benefits*, you must submit a claim form to *Tufts Health Plan*. (You are not required to submit claim forms for care you receive from *Tufts HP Providers*.)
- You may be required to *Preregister* and/or obtain prior authorization for certain *Covered Services*. If you do not *Preregister* and/or obtain prior authorization for these certain *Covered Services,* you will incur additional costs. Please see "Preregistration" on pages 32-34 and the "Important Notes" on page 39 for more information.

For more information, contact the Member Services Department.

Coinsurance

Except as shown in Part 1 (see "Benefit Overview" on pages 10-21), the *Member* pays 20% *Coinsurance* for all *Covered Services* provided by a Non-*Tufts HP Provider*. The *Plan* will cover the remaining charges for *Covered Services*, up to the *Reasonable Charge*. (The *Member* is responsible for any charges in excess of the *Reasonable Charge*.)

Out-of-Network Level of Benefits, continued

Individual *Deductible*

A $150 *Deductible* applies to each *Member* each *calendar year* for all *Covered Services* you receive at the *Out-of-Network Level of Benefits*. This is the amount you must first pay for *Covered Services* before the Navigator *Plan* will pay for any *Covered Services* at the *Out-of-Network Level of Benefits*.

If you receive *Covered Services* during the last three months of a *calendar year*, the amount you pay for those *Covered Services* that could be used to satisfy all or any portion of this *Deductible* may also be used to satisfy this *Deductible* for the next *calendar year*.

Family *Deductible*

A $300 Family *Deductible* applies each *calendar year* for all *Covered Services* obtained at the *Out-of-Network Level of Benefits*. This is how the Family *Deductible* works:

Two separate enrolled *Members* of a covered family must each satisfy his or her $150 Individual *Deductible* during a *calendar year*. Once this occurs, the rest of the covered *Members* of that family will not need to satisfy any *Deductible* for the remainder of that *calendar year*.

If the covered members of a family receive *Covered Services* during the last three months of a *calendar year*, the amount those family members pay for those *Covered Services* that could be used to satisfy all or any portion of this Family *Deductible* may also be used to satisfy this Family *Deductible* for the next *calendar year*.

Note: The *Out-of-Network Deductible* does not apply to:

1. *Outpatient Emergency* care and *Urgent Care* you receive in a hospital *Emergency* room.
2. Personal Emergency Response Systems (PERS).
3. Hearing aids.
4. The first pair of eyeglass lenses (eyeglass frames are not covered) and/or contact lenses needed after cataract surgery.
5. *Covered Services* in connection with the Coronary Artery Disease Program.

Out-of-Network Level of Benefits, continued

Out-of-Pocket Maximum

A $3,000 Individual *Out-of-Pocket Maximum* applies to you each *calendar year* for *Covered Services* you receive at the *Out-of-Network Level of Benefits*.

The only charges that satisfy this *Out-of-Pocket Maximum* are the *Deductible* and *Coinsurance* for *Covered Services* obtained at the *Out-of-Network Level of Benefits*. Once you satisfy the Individual *Out-of-Pocket Maximum* in a *calendar year*, all *Covered Services* you receive at the *Out-of-Network Level of Benefits* are covered in full up to the *Reasonable Charge* for the rest of that year.

Note: You cannot use the following services and supplies to satisfy this *Out-of-Pocket Maximum*:

1. Any service or supply that does not qualify as a *Covered Service*. This includes any services that require the approval of an *Authorized Reviewer* prior to treatment for which you do not obtain such approval.
2. Any amount that you must pay for a *Covered Out-of-Network Service* when the actual charges for the service exceed the *Reasonable Charge*.
3. Any amount you pay for a Personal Emergency Response System (PERS).
4. Any amount you pay for spinal manipulation (chiropractic care).
5. The amount you pay as a Preregistration Penalty or any other reduction or denial of benefits when you fail to preregister when required under the Navigator Plan. See pages 32-34 for more information.
6. Any *Copayment* or other amount you pay for In-Network *Covered Services*.
7. Any amount you pay for *Covered Services* in connection with the Coronary Artery Disease Program.
8. Any amount you pay for extended care facility services provided in a skilled nursing facility.

Preregistration Penalty

You must pay the Preregistration Penalty listed below for failure to preregister a hospitalization or hospital transfer in accordance with Part 3.

- ***In-Network Level of Benefits*:**

  There is no Preregistration Penalty for an *In-Network* hospitalization or an *In-Network* hospital transfer. Your *Tufts HP Provider* will preregister the procedure for you.

- ***Out-of-Network Level of Benefits***:

  You must pay a $500 Preregistration Penalty for failure to preregister a hospitalization or hospital transfer at the *Out-of-Network Level of Benefits* in accordance with Part 3. For more information, please see "Preregistration" in Part 3 (pages 32-34).

Note: This Preregistration Penalty cannot be used to meet the *Deductibles* or *Out-of-Pocket Maximums* described earlier in this section.

How the *Plan* Works

Eligibility for Benefits
When you need health care services, you may choose to obtain these services from either a *Tufts HP Provider* (*In-Network Level of Benefits*) or a non-*Tufts HP Provider* (*Out-of-Network Level of Benefits*). Your choice will determine the level of benefits you receive for your health care services.

The Plan covers only the services and supplies described as *Covered Services* in Part 5. There are no pre-existing condition limitations under this plan. You are eligible to use your benefits as of your *Effective Date*.

***Medically Necessary* services and supplies**
The *Plan* will pay for *Covered Services* and supplies when they are *Medically Necessary*, as determined by *Tufts Health Plan*. *Covered Services* must be provided by a *Tufts HP Provider* to be covered at the *In-Network Level of Benefits*. *Covered Services* provided by any non-*Tufts HP Provider* will be covered at the *Out-of-Network Level of Benefits*.

Important: The Navigator Plan will not pay for services or supplies which are not *Covered Services*, even if they are provided by a *Tufts HP Provider* or any other *Provider*.

In-Network Level of Benefits

***Outpatient* Care**
If your care is provided by a *Tufts HP Provider*, you are entitled to coverage for *Covered Services* at the *In-Network Level of Benefits*. You are not required to designate a *Primary Care Physician* (*PCP*); instead, you can choose to see any *Tufts HP Provider* to receive care at the *In-Network Level of Benefits*. When a *Tufts HP Provider* provides your care, you do not have to submit any claim forms. The claim forms are submitted to *Tufts Health Plan* by the *Tufts HP Provider*.

You pay a *Copayment* for certain *Covered Services* performed by *Tufts HP Providers*. For more information about your costs for medical services, see "Benefit Overview" and "*Plan* and Benefit Information" earlier in this *Member Handbook*.

***Inpatient* Care**
The Navigator Plan has two different *Copayment* Levels for *Inpatient* hospital stays at *Tufts HP Hospitals* for *Obstetric Services*, *Adult Medical and Surgical Services,* and *Pediatric Services*. *Copayments* vary based on which hospital you choose and on what type of services you receive.

Part 11 provides a list of the *Tufts HP Hospitals* and their *Copayment* Levels for the above services.

Important Note: *Inpatient* hospital *Copayments* are based on the hospital's quality and efficiency ratings.

In-Network Level of Benefits, continued

Important Note: Some *Tufts HP Hospitals* and services are not grouped in the *Copayment* Levels. These include:

- Hospitals that primarily provide specialty services, including the Dana Farber Cancer Institute, the Massachusetts Eye and Ear Infirmary, and the New England Baptist Hospital (a **$400 *Copayment*** applies per admission at these hospitals);
- Hospitals with fewer than 100 admissions for *Obstetric Services* or *Pediatric Services* (a **$400 *Copayment*** applies per admission for these services at these hospitals – see Part 11, pages 89-93);
- *Tufts HP Hospitals* that are located outside of Massachusetts (a **$400 *Copayment*** applies per admission at these hospitals); and
- Covered transplant services for *Members* at *Tufts Health Plan's In-Network* Transplant Centers of Excellence. **These services are subject to a $200 *Copayment* per admission.** Any additional *Inpatient* admission to an *In-Network Hospital* for *Covered Services* related to the transplant procedure(s) is subject to the applicable *Inpatient Hospital Copayment* in the "Navigator *Inpatient Hospital Copayment* List." Please see pages 89-93 of this Navigator *Member Handbook* for those *Copayment* amounts in effect as of July 1, 2008.

In addition, there are other services that are not included under these *Copayment* Levels. These include *Day Surgery*; certain care for newborn *Children*; and rehabilitation, extended care, and skilled nursing services at a skilled nursing facility, rehabilitation hospital, or chronic care facility. For information about your costs and limits for these services, please see "Benefit Overview" and Part 11 in this *Member Handbook*.

Selecting a *Provider*

In order to receive coverage at the *In-Network Level of Benefits*, you must receive care from a *Tufts HP Provider* listed in the *Directory of Health Care Providers*.

Notes:

- Under certain circumstances, if your physician is not in the *Tufts Health Plan* network, you will be covered for a short period of time at the *In-Network Level of Benefits* for services provided by your physician. Please see "Continuity of Care" on page 28.
- For additional information about a *Tufts HP Provider*, the Massachusetts Board of Registration in Medicine provides information about physicians licensed to practice in Massachusetts. You may reach the Board of Registration at (617) 654-9800 or **www.massmedboard.org.**

No Preregistration by You

As long as your *Inpatient* procedure is provided by a *Tufts HP Provider*, you are not responsible for preregistering the procedure. Your *Tufts HP Provider* will preregister the procedure for you. See "Preregistration" on pages 32-34 for more information.

Cancelling Appointments

If you have to cancel an appointment with any *Tufts HP Provider*, always give him or her as much notice as possible, but at least 24 hours. If the *Tufts HP Provider's* office policy is to charge for missed appointments that were not canceled in advance, you will have to pay the charges. The *Plan* will not pay for missed appointments that you did not cancel in advance.

Changes to the *Tufts Health Plan Provider* network

Tufts Health Plan offers *Members* access to an extensive network of physicians, hospitals, and other *Providers* throughout the *Service Area*. Although *Tufts Health Plan* works to ensure the continued availability of *Tufts HP Providers*, our network of *Providers* may change during the year.

This can happen for many reasons, including a *Provider's* retirement, the Provider's move out of the *Service Area*, or his or her failure to continue to meet *Tufts Health Plan's* credentialing standards. In addition, because *Providers* are independent contractors who do not work for *Tufts Health Plan*, this can also happen if *Tufts Health Plan* and the *Provider* are unable to reach agreement on a contract.

Out-of-Network Level of Benefits

Out-of-Network Level of Benefits

If your care is not provided by a *Tufts HP Provider*, you are entitled to coverage for *Covered Services* at the *Out-of-Network Level of Benefits*. You pay a *Deductible* and *Coinsurance* for certain *Covered Services* you receive at the *Out-of-Network Level of Benefits*. The *Member* is responsible for any charges in excess of the *Reasonable Charge*. For more information about your *Member* costs for medical services, see "*Plan* and Benefit Information" at the front of this *Member Handbook*.

Please note that you must submit a claim form for each service that is provided by a non-*Tufts HP Provider*. For information on filing claim forms, see page 71.

Covered Services* Not Available from a *Tufts HP Provider

If *Tufts Health Plan* determines that a *Covered Service* is not available from a *Tufts HP Provider*, with *Tufts Health Plan's* prior approval, you may go to a non-*Tufts HP Provider* and receive *Covered Services* at the *In-Network Level of Benefits* up to the *Reasonable Charge*. You are responsible for any charges in excess of the *Reasonable Charge.*

Preregistration by You

If you receive *Inpatient* services from a non-*Tufts HP Provider*, you must preregister these services. If you do not preregister, you will be subject to a Preregistration Penalty. See "Preregistration" on pages 32-34 for more information.

Continuity of Care

If you are an existing *Member*

If your *Provider* is involuntarily disenrolled from *Tufts Health Plan* for reasons other than quality or fraud, you may continue to see your *Provider* to obtain *Covered Services* at the *In-Network Level of Benefits* in the following circumstances:

- *Pregnancy*. If you are in your second or third trimester of pregnancy, you may continue to see your *Provider* through your first postpartum visit.
- *Terminal Illness*. If you are terminally ill, you may continue to see your *Provider*.

If you are enrolling as a new *Member*

When you enroll as a *Member*, if none of the health plans offered by the *GIC* includes your *Provider*, you may continue to see your *Provider* if:

- you are undergoing a course of treatment. In this instance, you may continue to see your *Provider* for *Covered Services* and receive the *In-Network Level of Benefits* for up to 30 days from your *Effective Date*.
- you are in your second or third trimester of pregnancy. In this instance, you may continue to see your *Provider* to obtain *Covered Services* at the *In-Network Level of Benefits* through your first postpartum visit.
- you are terminally ill. In this instance, you may continue to see your *Provider* to obtain *Covered Services* at the *In-Network Level of Benefits*.

Conditions for coverage of continued treatment

Tufts Health Plan may condition coverage of continued treatment for *Covered Services* at the *In-Network Level of Benefits* upon the *Provider's* agreement:

- to accept reimbursement from *Tufts Health Plan* at the rates applicable prior to notice of disenrollment as payment in full and not to impose cost sharing with respect to a *Member* in an amount that would exceed the cost sharing that could have been imposed if the *Provider* has not been disenrolled;
- to adhere to the quality assurance standards of *Tufts Health Plan* and to provide *Tufts HP* with necessary medical information related to the care provided; and
- to adhere to *Tufts Health Plan's* policies and procedures, including obtaining prior authorization and providing services pursuant to a treatment plan, if any, approved by the *Tufts HP*.

Emergency Care

To Receive *Emergency* Care
If you are experiencing an *Emergency*, you should seek care at the nearest *Emergency* facility. If needed, call 911 for emergency medical assistance. If 911 services are not available in your area, call the local number for emergency medical services.

***Outpatient Emergency* Care**
If you receive *Emergency* services but are not admitted as an *Inpatient*, the services will be covered at the *In-Network Level of Benefits*. You will be required to pay a *Copayment* for each *Emergency* room visit.

***Inpatient Emergency* Care**
If you receive *Emergency* services and are admitted as an *Inpatient* (in either a *Tufts HP Hospital* or a *non-Tufts HP Hospital*), you or someone acting for you must notify *Tufts Health Plan* within 48 hours of seeking care in order to be covered at the *In-Network Level of Benefits*. (Notification from the attending physician satisfies this requirement.) Otherwise, coverage for these services will be provided at the *Out-of-Network Level of Benefits*.

Also, if you are admitted as an *Inpatient* to a hospital that is a non-*Tufts HP Provider* after receiving *Emergency* care, that admission will be subject to *Inpatient Copayment Tier 1* (a $200 *Copayment* per admission). In addition, you must preregister the admission within 48 hours after you are admitted for *Inpatient Emergency* care or you will be charged a $500 Preregistration Penalty. Preregistration guidelines are described on pages 32-34.

Financial Arrangements between *Tufts Health Plan* and *Tufts HP Providers*

Methods of payment to *Tufts HP Providers*
Tufts Health Plan's goal in compensating *Providers* is to encourage preventive care and active management of illnesses. *Tufts Health Plan* strives to be sure that the financial reimbursement system we use encourages appropriate access to care and rewards *Providers* for taking the best care of our *Members*. *Tufts Health Plan* uses a variety of mutually agreed upon methods to compensate *Tufts HP Providers*.

The *Directory of Health Care Providers* indicates the method of payment for each *Provider*. Regardless of the method of payment, *Tufts Health Plan* expects all participating *Providers* to use sound medical judgment when providing care and when determining whether a referral for specialty care is appropriate. This approach encourages the provision of *Medically Necessary* care and reduces the number of unnecessary medical tests and procedures which can be both harmful and costly to *Members*.

Tufts Health Plan reviews the quality of care provided to *Members* through its Quality of Health Care Program. You should feel free to discuss specific questions with your *Provider* about how he or she is paid.

Member Identification Card

Introduction
Each *Member* receives a member identification card (member ID card).

Reporting errors
Call the Member Services Department if you notice any incorrect information on your member ID card.

Using your Member ID card
Your member ID card is important because it identifies your health care plan. Please remember to:

- carry your Member ID card at all times;
- have your Member ID card with you for medical, hospital and other appointments; and
- show your Member ID card to any *Provider* before you receive health care.

Member Identification Card, continued

Receiving services
When you receive services from a *Tufts HP Provider*, bring your Member ID card with you and be sure to identify yourself with the office staff as a Navigator *Member*. If you do not do this, the *Covered Services* you receive from that *Tufts HP Provider* may be covered at the *Out-of-Network Level of Benefits*.

Membership requirement
You are eligible for benefits if you are a *Member* when you receive care. A Member ID card alone is not enough to receive benefits. If you receive care when you are not a *Member*, you are responsible for the cost.

Membership identification number
If you have any questions about your member identification number, please call the Member Services Department.

Utilization Management

Tufts HP has a utilization management program. The purpose of the program is to evaluate whether health care services provided to *Members* are *Medically Necessary* and provided in the most appropriate and efficient manner. Under this program, *Tufts Health Plan* sometimes uses prospective, concurrent, and retrospective review of health care services.

Tufts Health Plan uses **prospective review** (also referred to as "pre-service review") to determine whether proposed treatment is *Medically Necessary* before that treatment begins. For example, *Tufts Health Plan* will not cover any *Inpatient* hospital admissions or hospital transfers unless its Preregistration Department has been notified of those health care services in advance. See "Preregistration" later in Part 3 for more information about the *Plan's* preregistration requirements.

Tufts Health Plan uses **concurrent review** to monitor the course of treatment as it occurs and to determine when that treatment is no longer *Medically Necessary*.

Retrospective review is used to evaluate care after the care has been provided. In some circumstances, *Tufts Health Plan* uses retrospective review to more accurately determine the appropriateness of health care services provided to *Members*. Retrospective review is also referred to as "post-service review".

If your request for coverage is denied, you have the right to file an appeal. See Part 7 for information on how to file an appeal.

Tufts HP makes coverage determinations. You and your *Provider* make all treatment decisions.

IMPORTANT NOTE: *Members* can call the Member Services Department at 1-800-870-9488 to determine the status or outcome of utilization review decisions.

Specialty case management
Some *Members* with severe illnesses or injuries may warrant case management intervention under *Tufts Health Plan's* specialty case management program. Under this program, *Tufts Health Plan*

- encourages the use of the most appropriate and cost-effective treatment; and
- supports the *Member's* treatment and progress.

The *Member* and his or her *Tufts HP Provider* may be contacted to discuss a treatment plan and establish short and long term goals. A Specialty Case Manager may suggest alternative treatment settings available to the *Member*.

Tufts Health Plan may periodically review the *Member's* treatment plan. The *Member* and the *Member's Tufts HP Provider* will be contacted if alternatives to the *Member's* current treatment plan are identified that:

- qualify as *Covered Services*;
- are cost effective; and
- are appropriate for the *Member*.

A severe illness or injury includes, but is not limited to, the following:

- high-risk pregnancy and newborn *Children*;
- serious heart or lung disease;
- cancer;
- certain neurological diseases;
- AIDS or other immune system diseases;
- severe traumatic injury.

Individual case management (ICM)
In certain circumstances, *Tufts Health Plan* may authorize an individual case management ("ICM") plan for a *Member* with a severe illness or injury. The ICM plan is designed to arrange for the most appropriate type, level, and setting of health care services and supplies for the *Member*.

As a part of the ICM plan, *Tufts Health Plan* may authorize coverage for alternative services and supplies that do not otherwise constitute *Covered Services* for that *Member*. This will occur only if *Tufts Health Plan* determines, in its sole discretion, that all of the following conditions are satisfied:

- the *Member's* condition is expected to require medical treatment for an extended duration;
- the alternative services and supplies are *Medically Necessary*;
- the alternative services and supplies are provided directly to the *Member* with the condition;
- the alternative services and supplies are in lieu of more expensive treatment that qualifies as *Covered Services*;
- the *Member* and an *Authorized Reviewer* agree to the alternative treatment program; and
- the *Member* continues to show improvement in his or her condition, as determined periodically by an *Authorized Reviewer*.

When *Tufts Health Plan* authorizes an ICM plan, the *Plan* will also indicate the *Covered Service* that the ICM plan will replace. The benefit available for the ICM plan will be limited to the benefit that the *Member* would have received for the *Covered Service*.

Tufts Health Plan will periodically monitor the appropriateness of the alternative services and supplies provided to the *Member*. If, at any time, these services and supplies fail to satisfy any of the conditions described above, the *Plan* may modify or terminate coverage for the services or supplies provided pursuant to the ICM plan.

Preregistration

Preregistration
Preregistration is *Tufts Health Plan's* process of prior authorization for all *Inpatient* hospital admissions and transfers. A review team will verify your eligibility at that time and assign an anticipated length-of-stay guideline for an approved hospital admission.

In certain cases, the review team will also
- evaluate your proposed medical care;
- verify whether that care is *Medically Necessary*; or
- recommend an alternative treatment setting.

Important note about preregistration
Preregistration does not guarantee that the *Plan* will cover the health care services you receive. The *Plan* is not obligated to cover any services or supplies that have been preregistered for any person who:
- is not a *Member* on the date services are provided;
- fails to meet other eligibility rules;
- receives services or supplies that are not *Covered Services*; or
- receives care that is not *Medically Necessary*, as determined by *Tufts Health Plan*.

When *Covered Services* are Provided by a *Tufts HP Provider*
When a *Tufts HP Provider* is directing your care, he or she is responsible for preregistering your *Inpatient* admission or transfer. In this case, you do not need to preregister the admission or transfer.

When *Covered Services* are Provided by a non-*Tufts HP Provider*
When your care is provided by a non-*Tufts HP Provider*, you are responsible for preregistering any *Inpatient* admission or transfer.

Important: If you do not preregister, you will be required to pay a $500 Preregistration Penalty for the care you receive in addition to the *Deductible* and *Coinsurance*. Please carefully read the following description of the preregistration process that you must complete when a *Tufts HP Provider* is not directing your care.

How to Preregister
You must call *Tufts Health Plan* at 617-972-9550 or 1-800-672-1515 to preregister your care. The Precertification Department is available Monday through Friday between 8:30 a.m. and 5:00 p.m. to accept preregistration information.

You, or someone acting on your behalf, will be asked to provide the following information:
- the patient name, address, and phone numbers (work and home);
- the *Member's* identification number (from your member ID);
- the admitting physician's name, address, and phone number;
- the admitting hospital's name, address, and phone number;
- the *Member's* diagnosis and proposed procedure; and
- the proposed admission and discharge dates.

Preregistration, continued

When *Covered Services* are Provided by a non -*Tufts HP Provider*, continued

When to preregister
You must preregister for the following services within the following time limits:

- For elective hospital admissions or transfers: You must preregister at least seven (7) days prior to hospitalization. After you call the Precertification Department, *Tufts Health Plan* will consult with your physician and then:
  - notify you or your physician of its preregistration determination, including the anticipated length-of-stay guidelines; or
  - recommend alternative treatment settings.

- For a hospital admission for *Urgent Care* - You must preregister immediately before you are admitted as a hospital *Inpatient*. An urgent admission is one which requires prompt medical intervention but one in which there is a reasonable opportunity to preregister prior to, or at the time of, admission.

- For a hospital admission for *Emergency* care - You or someone acting on your behalf must preregister within 48 hours after you are admitted as a hospital *Inpatient*.

- For maternity care for delivery of a newborn *Child* - Once you know the due-date for delivery of your newborn *Child*, you may preregister your delivery at any time prior to your due-date.

- For *Inpatient* hospital care for a newborn *Child* - You must preregister your newborn *Child*:

  - following a vaginal delivery, when the newborn *Child* remains as a hospital *Inpatient* for more than 48 hours after birth; or

  - following a cesarean delivery, when the newborn *Child* remains as a hospital *Inpatient* for more than 96 hours after birth.

  Note: If your newborn *Child* is a hospital *Inpatient* for less than 48 hours after birth, you do not need to preregister *Inpatient* hospital care for that *Child*.

Preregistration Penalty
You must preregister your *Inpatient* hospital admission or a transfer for *Out-of-Network* care, as described above. If you fail to meet any of the requirements for preregistration described in this Part 3, you must pay a $500 Preregistration Penalty. This Preregistration Penalty is in addition to any *Deductible* and *Coinsurance* that you are required to pay for that care.

After you preregister
After you call the Precertification Department with the required information, your physician or the hospital will be notified of the decision made by the review team.

Changes to preregistration information
Preregistration is valid only for the diagnosis, procedure, admission date, and medical facility specified at the time of preregistration. You must notify *Tufts Health Plan* about any delays, changes, or cancellations of your proposed hospital admission.

You must obtain a separate preregistration for
- a new date for your hospital admission;
- readmission or a new admission as a hospital *Inpatient*; or
- transfer to another facility.

Important: You must notify *Tufts Health Plan* about these changes before your hospital admission begins. If you fail to do this, you will be required to pay a $500 Preregistration Penalty for that admission.

Extending *Inpatient* Hospital Care (When Provided by a *Tufts HP* or non-*Tufts HP Provider*)

You or someone acting for you (for example, your physician) may contact *Tufts Health Plan* to request an extension of your *Inpatient* hospital care beyond the length of stay initially authorized by *Tufts Health Plan.*

Tufts Health Plan will review your request to extend your *Inpatient* hospital care. As a part of this review, you may be asked to provide additional information about your medical condition. If *Tufts Health Plan* determines that an extension of your *Inpatient* hospital care is *Medically Necessary*, additional hospital days may be authorized for you.

Important: *Tufts Health Plan* may determine that your *Inpatient* hospital care is no longer *Medically Necessary*. In this case, *Tufts Health Plan* will notify you that:

- the *Plan* will not pay for any additional hospital days; and
- you will be responsible for paying all hospital and physician charges, if you choose to remain as a hospital Inpatient beyond the length of stay initially authorized by *Tufts Health Plan*.

When to enroll
As a *Subscriber*, you may enroll yourself and your eligible *Dependents*, if any, for this coverage. Enrollment is subject to the provisions of Massachusetts General Laws, Chapter 32A, the *GIC* Rules and Regulations, and applicable federal law.

Please note that you and your eligible *Dependents*, if any, may enroll for this coverage only:

- during the *Annual Enrollment Period*;
- within 10 days of the date you (the *Subscriber*) are first eligible for this coverage; or
- within 31 days of the date your *Dependent* is first eligible for this coverage.

Note: If you fail to enroll for this coverage when first eligible, you may be eligible to enroll yourself and your eligible *Dependents*, if any, at a later date. This will apply only if you:

- declined this coverage when you were first eligible because you or your eligible *Dependent* was covered under another group health plan or other health insurance coverage at that time; or
- declined this coverage when you were first eligible, and you have acquired a *Dependent* through marriage, divorce, birth, adoption, or placement for adoption.

In these cases, you or your eligible *Dependent* may enroll for this coverage within 31 days after any of the following events:

- your coverage under the other health coverage ends involuntarily;
- your marriage or divorce; or
- the birth, adoption, or placement for adoption of your *Dependent Child*.

Effective Date

***Effective Date* of coverage**

Coverage begins on the first day of the month following the lesser of:

- sixty (60) days or two (2) calendar months of employment;
- the July 1st following the *Annual Enrollment Period* when this health care program is selected; or
- the date determined by the *GIC* for a late enrollment.

Adding *Dependents*

Introduction

This section explains how a *Subscriber* may add new *Dependents* under a *Family Plan*. After you enroll as a *Subscriber*, you may apply to enroll any eligible *Dependents* who are not currently enrolled in the Navigator Plan. This process will work as described below.

***Spouse* and/or *Dependent Children* Under Age 19**

- A *Spouse* and all eligible *Dependent Children* (under age 19) must enroll under a *Family Plan* in order to ensure coverage.
- *Subscribers* who are active employees enrolled under an *Individual Plan* must apply to their *GIC* Coordinator for a *Family Plan*. *Subscribers* who are retired employees must send a written request for a *Family Plan* to the *GIC*.
- *Members* already enrolled under a *Family Plan* on the date of marriage should notify their *GIC* Coordinator (if employed by the state or a *Participating Municipality*) or the *GIC* (if retired) and provide a copy of the marriage certificate if the *Member* wishes to add the *Spouse*.
- To add a *Dependent Child*, including a newborn, you must provide a copy of the *Child's* birth certificate to your *GIC* Coordinator (if employed by the state or a *Participating Municipality*) or to the *GIC* (if retired).

Newborn *Child*

Coverage for a newborn *Child* who is a natural *Child* will become effective on the *Child's* date of birth, provided that:

- *Members* enrolled under an *Individual Plan* arrange for a *Family Plan* by notifying the *GIC* Coordinator at their worksite. The *GIC* must receive a written request to change the membership to a *Family Plan* not more than thirty-one (31) days after the *Child's* date of birth.
- *Members* already enrolled under a *Family Plan* when the *Child* is born must notify their *GIC* Coordinator within thirty-one (31) days after the *Child's* date of birth that the newborn must be added to the membership.

Note: For more information, see "Additional Information About Newborn *Children*" on page 37.

Adoptive Child

A *Child* who is legally adopted must be enrolled under a *Family Plan* within thirty-one (31) days after the adoption or placement for adoption in order to ensure coverage for that *Child*. Active employees enrolled under an *Individual Plan* must arrange for a *Family Plan* by notifying the *GIC* Coordinator at their worksite. Retirees must notify the *GIC* in writing.

***Dependents* 19 and Over (Continued *Dependent* Coverage)**

A *Dependent Child* who reaches age 19 is no longer automatically eligible for coverage under this *Plan*. In order to continue coverage for a *Dependent* age 19 and over, you must complete all of the following steps:

1. Complete the written application that the *GIC* will send you prior to the *Dependent's* 19th birthday;
2. Complete subsequent eligibility recertification forms; and
3. Return all of the completed forms as instructed by the *GIC.* If the forms are returned late, your *Dependent* may have a gap in coverage.

The following types of *Dependents* age 19 and over are eligible for coverage:

- *Student Dependents*: Coverage is available under a *Family Plan* for a *Child* who is a full-time student at the age of 19 and enrolled in an accredited educational institution. *Members* must apply to the *GIC* for *Student Dependent* Coverage. The *GIC* requires verification of full-time student status for any *Member* enrolled as a *Student Dependent* under a *Family Plan*.
- Full-time students age 26 and over: A full-time student at an accredited educational institution at age 26 or over may elect to continue coverage as an individual *Member* under the *Plan* at 100% of the required premium. That student must file a written application with the *GIC* and the application must be approved by the *GIC.*
- A *Dependent* age 19 or over but under age 26 who is a *Dependent* under the Internal Revenue Code is eligible for coverage under this *Plan.*
- A *Dependent* age 19 or over until the earlier of two years following the loss of *Dependent* status under the Internal Revenue Code or age 26 is eligible for coverage under this *Plan.*

Note: Failure to recertify coverage when required will result in termination of continued *Dependent* coverage. See "When Coverage Ends" below for more information.

Adding *Dependents*, continued

Handicapped Child
Coverage is available under a *Family Plan* for a *Handicapped Child* who is age 19 or older, provided that the *Child* was either mentally or physically handicapped so as not to be capable of earning his or her own living on the date he or she reached age 19. Special arrangements must be made with the *GIC* for the Disabled *Child* to continue coverage. To request this continuation of coverage, a request letter must be sent to the GIC at the following address:

Group Insurance Commission
Continued Coverage Unit
P.O. Box 8747
Boston, MA 02114

Children* of *Dependent Children
Coverage is available for the *Children* of *Dependent Children* who are enrolled under a *Family Plan*. Coverage for the *Dependent's Child* will become effective on the *Child's* date of birth, provided that the *GIC* is notified in writing not more than thirty-one (31) days after the date of birth that the *Child* of the *Dependent Child* must be added to the *Family Plan*.

Former *Spouses*
In accordance with state law, coverage for the former *Spouse* ends if either party remarries. A former *Spouse* who is enrolled under a *Family Plan* may be able to continue coverage under the *Family Plan* in the event of divorce or legal separation. Contact the *GIC* for information about continuation of coverage in this circumstance.

***Members* Age 65 and Eligible for Medicare**
Coverage is available under this *Plan* only until the first day of the month in which a retired *Subscriber* turns 65 years of age and becomes eligible to enroll in the Medicare Program (Parts A and B); the *Subscriber's* family members who are under age 65 may stay on the *Plan*. The *Subscriber* (or *Spouse* and/or *Dependent Children*) will have the option of continuing coverage under this *Plan* when the *Subscriber* remains as an actively working employee after reaching age 65.

Residence Requirement
Every individual covered by a *Family Plan* must reside in the *Plan's Service Area* for at least 9 months of the year, except for full-time students. Please contact the *GIC* at 617-727-2310, ext. 1 if this is not the case.

Additional Information About Newborn *Children*

Care at the *In-Network Level of Benefits*
The *Plan* will cover your newborn *Child* from birth under a *Family Plan* at the *In-Network Level of Benefits* for *Covered Services* for *Routine Nursery Care* and other *Medically Necessary* care, when:

- the *Subscriber* enrolls the newborn *Child* within 31 days after birth;
- the newborn *Child's* care is obtained from a *Tufts HP Provider*.

Care at the *Out-of-Network Level of Benefits*
The *Plan* will cover your newborn *Child* from birth under a *Family Plan* at the *Out-of-Network Level of Benefits* for *Routine Nursery Care* and other *Medically Necessary* care when the *Subscriber* enrolls the newborn *Child* within 31 days after birth and the newborn *Child's* care is not obtained from a *Tufts HP Provider*.

If the *Subscriber* does not enroll the newborn *Child* within 31 days after birth, the Navigator Plan will only cover that newborn *Child* at birth for an initial 31-day period. During this period, the Navigator Plan will only cover the newborn *Child* at the *Out-of-Network Level of Benefits* and will only cover *Routine Nursery Care* for:

- up to 48 hours, in the case of a vaginal delivery; and
- up to 96 hours, in the case of a caesarean delivery.

To continue coverage for the newborn *Child* after this 31-day period, the *Subscriber* must apply to enroll the *Child* by contacting the *GIC* Coordinator at his or her worksite (if employed) or the *GIC* (if retired).

When Coverage Ends

Subscribers

Active employee *Subscribers* may terminate their coverage in the *Plan* by providing prior written notice to the *GIC* Coordinator at their worksite. Retired *Subscribers* may terminate their coverage in the *Plan* by sending their written request to the *GIC*.

Otherwise, this *Plan* will end when:

- A *Subscriber* is no longer eligible for health care coverage with the *GIC* (for example, the hours are reduced to less than half-time or the *Subscriber* leaves the job). In this case, coverage under this health care program ends at the end of the month following the month during which he or she loses eligibility.
- A *Subscriber* stops paying his or her share of the cost of this health care program. In this case, coverage ends at the end of the period covered by his or her last contribution payment.
- A *Subscriber* reaches age 65, becomes eligible for Medicare and retires (or is already retired). Contact the *GIC* for more information about the options to continue health care coverage.
- the *GIC* ends this health care program.
- A *Subscribe*r moves out of the *Service Area*. In order to remain enrolled in the Navigator plan, the *Subscriber* must remain in the *Service Area* for 9 months in each *calendar year*.

Spouse* and/or *Dependent Children

Coverage for a *Spouse* and/or *Dependent Children* enrolled under a *Family Plan* will end when:

- The *Subscriber's* coverage ends, as described in the provision captioned "*Subscribers*" above.
- At the end of the month in which the *Dependent Child* reaches age 19, unless he or she:
  - qualifies for continued *Dependent* coverage; or
  - is a *Handicapped Child*, as determined by the *GIC*.
- The *Dependent Child* marries.
- Two years following the loss of *Dependent* status under the Internal Revenue Code or age 26, whichever occurs first.
- The divorced *Spouse* is no longer eligible for coverage under this health care program.
- The *Spouse* reaches age 65 and becomes eligible for Medicare, unless the *Subscriber* remains an active employee and this *Plan* remains the family's primary coverage.

In any of the situations described above, coverage under this *Plan* ends when the *Spouse* and/or *Dependent Children* lose their eligibility under this *Plan*.

Part 5 - Covered Services

Covered Services

When health care services are *Covered Services*
Health care services and supplies are *Covered Services* only if they are:

- listed as *Covered Services* in this Part 5;
- *Medically Necessary*, as determined by *Tufts Health Plan*;
- consistent with applicable law;
- consistent with *Tufts Health Plan's Medical Necessity* Guidelines in effect at the time the services or supplies are provided. This information is available to you on the Web site at **www.tuftshealthplan.com** or by calling Member Services;
- provided to treat an injury, illness or pregnancy, except for preventive care; and
- approved by an *Authorized Reviewer*, in some cases.

Important Notes:

- Certain *Covered Services* require the prior approval of an *Authorized Reviewer* at both the In-Network and *Out-of-Network Level of Benefits* (see "Benefit Overview" to determine which services require this prior approval).
  - If you receive these services from a *Tufts HP Provider (In-Network Level of Benefits)*, that *Provider* is responsible for obtaining approval from *Tufts Health Plan*.
  - If you receive these services from a non-*Tufts HP Provider (Out-of-Network Level of Benefits)*, you are responsible for obtaining prior approval from *Tufts HP*. If prior approval is not received, the Navigator Plan will not cover those services and supplies. For more information about how to obtain this prior approval, please call Member Services.
- Preregistration: You must preregister Out-of-Network *Inpatient* services. Please see "Preregistration" in Part 3 (pages 32-34) for more information.
- All claims for services (whether or not the services were provided by a *Tufts HP Provider*) are subject to retrospective review by an *Authorized Reviewer*. *Authorized Reviewers* review claims to be sure that the claims are for *Covered Services*. A *Covered Service* is one that is described in Part 5. Only claims that are for *Covered Services* will be paid by the *Plan*.

YOUR COSTS FOR *COVERED SERVICES*:

- For information about your costs for the *Covered Services* listed below, (for example, *Copayments*, *Coinsurance*, and *Deductibles*), see the "Benefit Overview" starting on page 10.
- Information about the day, dollar, and visit limits under this plan is listed in the "Benefit Overview" starting on page 10 and in certain *Covered Services* listed below.

Emergency Care

- Care for an *Emergency* in an *Emergency* room;
- Care for an *Emergency* in a physician's office.

Notes:

- The *Emergency* Room *Copayment* is waived if the *Emergency* room visit results in an immediate hospitalization. The applicable *Inpatient Copayment* will apply for that hospital admission.
- The *Emergency* Room *Copayment* is waived if the *Emergency* room visit results in an immediate *Day Surgery.* The *Day Surgery Copayment* may apply if *Day Surgery* services are received. If you are admitted to the hospital immediately following that *Day Surgery*, the *Day Surgery Copayment* will be waived and you will instead be required to pay the applicable *Inpatient Copayment* for that hospital admission. Call Member Services for more information.
- An *Emergency* Room *Copayment* may apply if you register in an emergency room but leave that facility without receiving care.
- *Emergency Covered Services* received from a non-*Tufts HP Provider* are subject to the applicable *Copayment* (*Emergency* Room or Office Visit *Copayment)* up to the *Reasonable Charge.* In the event that you receive a bill for these services from a non-*Tufts HP Provider,* please contact the Member Services Department at 1-800-870-9488. You are responsible for any charges in excess of the *Reasonable Charge.*

Outpatient care

Cardiac rehabilitation

Services for *Outpatient* treatment of documented cardiovascular disease that:

- meet the standards promulgated by the Massachusetts Commissioner of Public Health, and
- are initiated within 26 weeks after diagnosis of cardiovascular disease.

The *Plan* covers only the following services:

- the *Outpatient* convalescent phase of the rehabilitation program following hospital discharge; and
- the *Outpatient* phase of the program that addresses multiple risk reduction, adjustment to illness and therapeutic exercise.

Notes:

- Once treatment has been initiated, the *Member* can receive covered cardiac rehabilitation services for up to 6 months from the date of the first visit.
- For *Members* with *angina pectoris*, only one course of cardiac rehabilitation services will qualify as *Covered Services*.
- The *Plan* does not cover the program phase that maintains rehabilitated cardiovascular health.

Contraceptives – See "Family Planning Procedures, Services, and Contraceptives" on page 41.

Coronary Artery Disease Program

The Coronary Artery Disease secondary prevention program is designed to assist you in making necessary lifestyle changes that can reduce your cardiac risk factors.

Note: This benefit is available at designated programs when *Medically Necessary* to *Members* with documented Coronary Artery Disease who meet the clinical criteria established for this program.

For more information about this program, *Members* should call the Member Services Department.

Outpatient **Care - continued**

Diabetes self-management training and educational services
Outpatient self-management training and educational services, including medical nutrition therapy, used to diagnose or treat insulin-dependent diabetes, non-insulin dependent diabetes, or gestational diabetes.

Important Notes:

- *Tufts Health Plan* will only cover these services at the *In-Network Level of Benefits* when provided by a *Tufts HP Provider* who is a certified diabetes health care provider.
- Medical nutritional therapy provided under this benefit is not subject to any visit limit described in the "Nutritional counseling" benefit on page 43.

Early intervention services for a *Dependent Child*
Services provided by early intervention programs that meet the standards established by the Massachusetts Department of Public Health. Early intervention services include:

- occupational therapy;
- physical therapy;
- speech therapy;
- nursing care; and
- psychological counseling.

These services are available to *Members* from birth until their third birthday.

Note: Early intervention services are covered up to a total of $5,200 per *calendar year*, and a lifetime maximum of $15,600.

Family planning procedures, services, and contraceptives

Family planning procedures

- tubal ligation;
- sterilization; and
- pregnancy termination.

Family planning services

- medical examinations;
- birth control counseling; and
- genetic counseling.

Contraceptives

The following contraceptives are available, when provided by a physician and administered in that physician's office:

- Cervical caps;
- implantable contraceptives (e.g., Implanon® (etonorgestrel), levonorgestrel implants);
- IUDs;
- Depo-Provera or its generic equivalent.

Note: Please note that *Tufts HP* covers certain contraceptives, such as oral contraceptives and diaphragms, under your Prescription Drug Benefit.

Hemodialysis

- *Outpatient* hemodialysis; and
- *Outpatient* peritoneal dialysis.

Note: Benefits for home hemodialysis also qualify as a *Covered Service*, but only when provided under the direction of a general or chronic disease hospital or free-standing dialysis facility.

Outpatient care – continued

Infertility services (must be approved by an *Authorized Reviewer*)

Diagnosis and treatment of Infertility* in accordance with applicable law.

Note: Oral and injectable drug therapies used in the treatment of infertility associated with the *Covered Services* below are considered *Covered Services* only when the *Member* has been approved for associated infertility services. See your Prescription Drug Benefit section for your *Copayment* amounts.

Infertility services include:

(I.) the following services and supplies provided in connection with an infertility evaluation:

- diagnostic procedures and tests;
- artificial insemination (intrauterine or intracervical) when performed with non-donor (partner) sperm; and
- procurement, processing, and long-term (longer than 90 days) banking of sperm when associated with active infertility treatment.

(II.) the following procedure when approved in advance by an *Authorized Reviewer* (see "Important Notes" on page 39 in this Navigator *Member Handbook* for more information):

- artificial insemination (intrauterine or intracervical) when performed with donor sperm and/or gonadotropins; and
- procurement and processing of eggs or inseminated eggs or banking of inseminated eggs when associated with active infertility treatment.

Note: Donor sperm is only covered when the partner has a diagnosis of male factor infertility.

(III.) the following Assisted Reproductive Technology ("ART") procedures when approved in advance by an *Authorized Reviewer***:

- I.V.F. (in-vitro fertilization and embryo transfer);
- D.O. (donor oocyte);
- F.E.T. (frozen embryo transfer);
- Z.I.F.T. (zygote intra-fallopian transfer);
- G.I.F.T. (gamete intra-fallopian transfer); and
- I.C.S.I. (intracytoplasmic sperm injection).

**Note: These ART procedures will only be considered *Covered Services* for *Members* with Infertility:

- who meet *Tufts HP's* eligibility requirements, which are based on the *Member's* medical history;
- who meet the eligibility requirements of *Tufts Health Plan's* contracting Infertility Services providers;
- when approved in advance by an *Authorized Reviewer* at both the *In-Network* and *Out-of-Network Levels of Benefits* (see "Important Notes" on page 39 of this Navigator *Member Handbook* for more information about when you are responsible for obtaining this approval); and
- with respect to the procurement and processing of donor sperm, eggs, or inseminated eggs, or the banking of sperm or inseminated eggs, to the extent such costs are not covered by the donor's health care coverage, if any.

Coverage for Assisted Reproductive Technology (ART) is provided only when *Medically Necessary* and is subject to approval in advance by an *Authorized Reviewer* at both the *In-Network* and *Out-of-Network Levels of Benefits* (see "Important Notes" on page 39 of Part 5 for more information about when you are responsible for obtaining this approval). ART services are provided up to a maximum of 5 attempts. Exceptions will be made only when *Tufts Health Plan* determines the services to be *Medically Necessary*.

*Infertility is defined as the condition of a presumably healthy *Member* who has been unable to conceive or produce conception during a period of one year.

***Outpatient* Care – continued**

Maternity Care

- Prenatal care, exams, and tests; and
- postpartum care provided in a physician's office.

***Outpatient* medical care**

- Allergy testing (including antigens) and treatment, and allergy injections.

  Note: Allergy treatment (for example, an allergy shot) provided to you at the *In-Network Level of Benefits* is subject to an Office Visit *Copayment* when received as part of an office visit. However, there may not be a *Copayment* if the sole purpose of your visit is to receive allergy treatment (for example, an allergy shot).
- Chemotherapy.
- Cytology examinations (Pap Smears) - one annual screening for women age 18 and older, or as otherwise *Medically Necessary*;
- Diagnostic screening procedures (including, for example, colonoscopies, endoscopies, sigmoidoscopies, and proctosigmoidoscopies);

  Note: Please see page 14 of the "Benefit Overview" for information about *Copayments* applicable to these procedures.
- Diagnostic imaging, including general imaging (such as x-rays and ultrasounds), and MRI/MRA, CT/CTA, and PET tests and cardiology medicine. Important Note: Prior authorization may be required for MRI/MRA, CT/CTA, PET and nuclear cardiology. Please call Member Services for more information.
- Human leukocyte antigen testing or histocompatibility locus antigen testing for use in bone marrow transplantation when necessary to establish a *Member's* bone marrow transplant donor suitability. Includes costs of testing for A, B or DR antigens; or any combination consistent with the rules and criteria established by the Department of Public Health.
- Laboratory tests, including, but not limited to, blood tests, urinalysis, throat cultures, glysolated hemoglobin (A1c) tests, genetic testing, and urinary protein/microalbumin and lipid profiles. **Important:** Some laboratory tests (e.g., genetic testing) may require the approval of an *Authorized Reviewer* at both the *In-Network* and *Out-of-Network Levels of Benefits.* Please see "Important Notes" on page 39 of this Navigator *Member Handbook* for more information about when you are responsible for obtaining this approval);
- Mammograms at the following intervals:
  - one baseline at 35-39 years of age,
  - one every year at age 40 and older,
  - or as otherwise *Medically Necessary*;
- *Medically Necessary* diagnosis and treatment of speech, hearing and language disorders (services may require the approval of an *Authorized Reviewer*). These services include speech therapy.
- Neuropsychological testing, when provided for a medical condition (services may require the approval of an *Authorized Reviewer*).

  Important Note: Neuropsychological testing provided for a mental health condition is **not** covered under this Medical and Prescription Drug Benefit section of your Navigator Plan administered by *Tufts Health Plan*. For information about testing covered for mental health conditions, please refer to the section of this Member Handbook (see **pages 94-108**) that describes the EAP/Mental Health and Substance Abuse Plan administered by United Behavioral Health.
- Nutritional counseling, when given outside of an approved home health care plan. Coverage is provided for one initial evaluation and a total of 3 treatment visits per *calendar year*.

  Note: This visit limit does not apply to *Outpatient* nutritional counseling provided as part of:
  - an approved home health care plan (see "Home health care" benefit on page 51); or
  - diabetes self-management training and educational services (see benefit on page 41).

Outpatient **Care – continued**

Outpatient **medical care *(continued)***

- Office visits to diagnose and treat illness or injury.
  Note: This includes *Medically Necessary* evaluations and related health care services for acute or *Emergency* gynecological conditions.
- *Outpatient* surgery in a physician's office.
- Radiation therapy and x-ray therapy.
- Voluntary second or third surgical opinions.

Patient care services provided as part of a qualified clinical trial for the treatment of cancer

As required by Massachusetts law, patient care services provided as part of a qualified clinical trial for the treatment of cancer are covered to the same extent as those *Outpatient* services would be covered if the *Member* did not receive care in a qualified clinical trial.

Preventive health care – Adults (age 18 and over)

- Routine physical examinations, including appropriate immunizations and lab tests as recommended by the physician.
- Immunizations and lab tests, when not rendered as part of a routine physical exam.
- Hearing examinations and screenings.

Preventive health care – *Children* (under age 18)

- preventive care services from the date of birth until age 18, including:
  - physical examination,
  - history,
  - measurements,
  - sensory screening,
  - neuropsychiatric evaluation, and
  - developmental screening and assessment at the following intervals:
    - birth until age 6 months - 6 visits;
    - age 6 months until age 18 months - 6 visits;
    - age 18 months until age 3 - 6 visits;
    - age 3 until age 18 - 1 visit per *calendar year*.
- Coverage is also provided for:
  - hereditary and metabolic screening at birth;
  - appropriate immunizations and tuberculin tests;
  - hematocrit, hemoglobin, or other appropriate blood tests;
  - urinalysis as recommended by the physician; and
  - newborn auditory screening tests, as required by state law.

Routine annual gynecological exams

Includes any follow-up obstetric or gynecological care determined to be *Medically Necessary* as a result of that exam.

Outpatient **care – continued**

Short term physical and occupational therapy services (services may require the approval of an *Authorized Reviewer*)

Physical and occupational therapy services are covered for up to 90 consecutive days per injury or illness beginning with the first visit. These services are covered only when provided to restore function lost or impaired as the result of an accidental injury or sickness.

For these services to be covered, *Tufts Health Plan* must determine that the *Member's* condition is subject to significant improvement as a direct result of these therapies.

Note: Massage therapy may be covered as a treatment modality only when administered as part of a physical therapy visit that is:

- provided by a licensed physical therapist; and
- in compliance with *Tufts Health Plan's Medical Necessity* guidelines, and, if applicable, prior authorization guidelines.

Vision Care Services

Includes the following services:

- Routine eye exams: Coverage includes one routine eye exam in each 24-month period (*In-Network* and *Out-of-Network* combined).
- Other vision care services -- Coverage is provided for eye examinations and necessary treatment of a medical condition.

Oral health services (in some cases must be approved by an *Authorized Reviewer*)

Emergency **Care**

Benefits are provided for treatment rendered by a dentist within 72 hours of an accidental injury to the mouth and sound natural teeth. This treatment is limited to initial first aid (trauma care), reduction of swelling, pain relief, covered non-dental surgery and non-dental diagnostic x-rays.

Notes:

- *Emergency* Care qualifies as a *Covered Service* only if the injury to the mouth is caused by a source external to the mouth;
- *Covered Services* do not include any repair or restoration of teeth.

Oral Surgery for Dental Treatment in an *Inpatient* or *Day Surgery* setting

Benefits are provided only for the following procedures when the *Member* has a serious medical condition that makes it essential that he or she be admitted to a general hospital as an *Inpatient* or to a *Day Surgery* unit or ambulatory surgical facility as an *Outpatient* in order for the dental care to be performed safely:

1. extraction of seven or more permanent, sound natural teeth;
2. gingivectomies (including osseous surgery) of two or more gum quadrants;
3. excision of radicular cysts involving the roots of three or more teeth; and
4. removal of one or more bone impacted teeth.

Serious medical conditions include, but are not limited to, hemophilia and heart disease.

Note: The above services are not covered when performed in an office setting.

Oral surgical procedures for non-dental medical treatment

Benefits are provided for oral surgical procedures for non-dental medical treatment such as the reduction of a dislocated or fractured jaw or facial bone, and removal or excision of benign or malignant tumors, are covered to the same extent as other covered surgical procedures.

Day Surgery

- *Outpatient* surgery done under anesthesia in an operating room of a facility licensed to perform surgery.
- You must be expected to be discharged the same day and be shown on the facility's census as an *Outpatient*.

Notes:

- If you are admitted to a *Tufts HP Hospital* immediately following *Day Surgery,* the *Day Surgery Copayment* will be waived. You will instead be required to pay the applicable *Inpatient Copayment* for that hospital admission. Call Member Services for more information.
- Prior approval by an *Authorized Reviewer* is required for certain *Day Surgeries* at both the *In-Network* and *Out-of-Network Levels of Benefits.* See "Important Notes" on page 39 of this Navigator *Member Handbook* for more information about which *Day Surgeries* require this approval and about when you are responsible for obtaining this approval.

***Inpatient* care**

Important Note: At the *In-Network Level of Benefits, Members* will only be responsible for one *Inpatient Copayment* if readmitted within 30 days of discharge. Please call Member Services to arrange to have the second *Copayment* waived.

Acute hospital services

- semi-private room (private room when *Medically Necessary*);
- physician's services while hospitalized;
- surgery*;
- anesthesia;
- nursing care;
- intensive care/coronary care;
- diagnostic tests, imaging, and lab services;
- radiation therapy;
- dialysis;
- physical, occupational, speech, and respiratory therapies;
- *Durable Medical Equipment* and appliances; and
- drugs.

***Note:** Prior approval by an *Authorized Reviewer* is required for these services at both the *In-Network* and *Out-of-Network Levels of Benefits.* See "Important Notes" on page 39 of this Navigator *Member Handbook* for more information about when you are responsible for obtaining this approval.

Bone Marrow Transplants for Breast Cancer, Hematopoietic Stem Cell Transplants, and Human Solid Organ Transplants

Authorized Reviewer approval is required regardless of whether the procedure is provided by a *Tufts HP Provider* or a non-*Tufts HP Provider*.

- Bone marrow transplants for *Members* diagnosed with breast cancer that has progressed to metastatic disease who meet the criteria established by the Massachusetts Department of Public Health.

- Hematopoietic stem cell transplants and human solid organ transplants provided to *Members*. These services must be provided at a *Tufts Health Plan* designated transplant facility. The *Plan* pays for charges incurred by the donor in donating the organ to the *Member*, but only to the extent that charges are not covered by any other health insurer. This includes:
  - evaluation and preparation of the donor, and
  - surgery and recovery services when those services relate directly to donating the organ to the *Member*.

Notes:

- The *Plan* **covers** a *Member's* human leukocyte antigen (HLA) testing. See page 43 in "*Outpatient* care" for more information.
- The *Plan* **does not cover** the following services related to bone marrow and human organ transplants:
  - transportation costs incurred in transporting the donated stem cells or solid organ;
  - donor charges of *Members* who donate stem cells or solid organs to non-*Members*; and
  - search costs for matching or for laboratory testing:
    - to identify a donor for a recipient who is a *Member*, or
    - or a *Member* who volunteers to be considered as a potential stem cell or solid organ donor, whether or not the recipient is a *Member*.
- Prior approval by an *Authorized Reviewer* is required at both the *In-Network* and *Out-of-Network Levels of Benefits*. See "Important Notes" on page 39 for more information about when you are responsible for obtaining this approval.

Maternity Care

- hospital and delivery services;
- a newborn hearing screening test; and
- well newborn *Child* care in hospital.

Includes *Inpatient* care in hospital for mother and newborn *Child* for at least 48 hours following a vaginal delivery and 96 hours following a caesarean delivery.

Notes:

- *Covered Services* will include one home visit by a registered nurse, physician, or certified nurse midwife; and additional home visits, when *Medically Necessary* and provided by a licensed health care *Provider*. *Covered Services* will include, but not be limited to, parent education, assistance, and training in breast and bottle feeding, and the performance of any necessary and appropriate clinical tests.
- These *Covered Services* will be available to a mother and her newborn *Child* regardless of whether or not there is an early discharge (hospital discharge less than 48 hours following a vaginal delivery or 96 hours following a caesarean delivery).

For information about preregistration of newborn *Children*, see Part 3 (pages 32-34).

IMPORTANT NOTES - Benefits for Newborn *Children* at Time of Delivery:

1. *Member's* Delivery is Performed by a *Network Provider*

If a mother is a *Member* whose delivery was performed by a *Network Provider*, the *Plan* will pay for *Medically Necessary* care as follows:

When newborn *Child* is enrolled: If the newborn *Child* is enrolled under the *Plan* as described under "Adding *Dependents*" in Part 4:

- The *Plan* will pay for *Routine Nursery Care* at the *In-Network Level of Benefits*; and
- The *Plan* will pay for *Medically Necessary* care other than *Routine Nursery Care*: (1) at the *In-Network Level of Benefits*, if that care is provided by a *Network Provider*, and (2) at the *Out-of-Network Level of Benefits*, if that care is not provided by a *Network Provider* (*Preregistration* is required).

When newborn *Child* is not enrolled: If the newborn *Child* is not enrolled under the *Plan* as described under "Adding *Dependents*" in Part 4, the *Plan* will pay (1) for *Routine Nursery Care* at the *In-Network Level of Benefits*; and (2) will not pay for care other than *Routine Nursery Care*.

2. Non-*Member's* Delivery

Massachusetts law requires a newborn *Child's Routine Nursery Care* to be covered under the maternity coverage benefits of the mother's health plan. If the mother is not a *Member* under the *Plan* and has no other maternity coverage benefits, the *Plan* will cover *Medically Necessary* care that the newborn *Child* may require (either *Routine Nursery Care* or other care) if that newborn *Child* is enrolled in the *Plan*.

When newborn *Child* is enrolled: If the newborn *Child* is enrolled under the *Plan* (e.g. enrolled by the father, who is a *Subscriber*) as described under "Adding *Dependents*" in Part 4:

- The *Plan* will pay for *Routine Nursery Care* (1) at the *In-Network Level of Benefits,* if that care is provided by a *Network Provider,* and (2) *at* the *Out-of-Network Level of Benefits,* if that care is not provided by a *Network Provider* (*Preregistration* is required); and
- The *Plan* will pay for *Medically Necessary* care other than *Routine Nursery Care* (1) at the *In-Network Level of Benefits*, if that care is by a *Network Provider*, and (2) at the *Out-of-Network Level of Benefits*, if that care is not provided by a *Network Provider* (*Preregistration* is required).

When Newborn *Child* is not enrolled: If the newborn *Child* is not enrolled under the *Plan* as described under "Adding *Dependents*" in Part 4, the *Plan* will not pay for any care for the newborn *Child*.

Patient care services provided as part of a qualified clinical trial for the treatment of cancer

As required by Massachusetts law, patient care services provided as part of a qualified clinical trial for the treatment of cancer are covered to the same extent as those *Inpatient* services would be covered if the *Member* did not receive care in a qualified clinical trial.

Reconstructive surgery and procedures
(must be approved by an *Authorized Reviewer*)

- services required to repair or restore a bodily function that is impaired as a result of a congenital defect, birth abnormality, traumatic injury, or covered surgical procedure; and
- the following services in connection with mastectomy:
  - reconstruction of the breast affected by the mastectomy;
  - surgery and reconstruction of the other breast to produce a symmetrical appearance; and
  - prostheses* and treatment of physical complications of all stages of mastectomy.

    **Prosthetic Devices* are covered as described under "Medical Appliances and Equipment " on page 52.

Removal of breast implants is covered when any one of the following conditions exists:

- the implant was placed post-mastectomy;
- there is documented rupture of a silicone implant; or
- there is documented evidence of auto-immune disease.

Important: No coverage is provided for the removal of ruptured or intact saline breast implants or intact silicone breast implants except as specified above.

Notes:

- Cosmetic Surgery is not covered.
- Except as described above in connection with a mastectomy, *Authorized Reviewer* approval is required before you receive any reconstructive surgery or procedure. This prior approval by an *Authorized Reviewer* is required at both the *In-Network* and *Out-of-Network Levels of Benefits*. See “Important Notes” on page 39 of this Navigator *Member Handbook* for more information about when you are responsible for obtaining this approval.

Other Health Services

Ambulance services

- Ground, sea, and helicopter ambulance transportation for *Emergency* care.
- Airplane ambulance services (e.g., Medflight) when approved by an *Authorized Reviewer**.
- Non-emergency, *Medically Necessary* ambulance transportation between covered facilities.
- Non-emergency ambulance transportation for *Medically Necessary* care when the medical condition of the *Member* prevents safe transportation by any other means. Prior approval by an *Authorized Reviewer* is required*.

*Prior approval by an *Authorized Reviewer* is required for these benefits at both the *In-Network* and *Out-of-Network Levels of Benefits.* See "Important Notes" on page 39 of this Navigator *Member Handbook* for more information about when you are responsible for obtaining this approval.

Important Notes:

- If you are treated by Emergency Medical Technicians (EMTs) or other ambulance staff, but refuse to be transported to the hospital or other medical facility, you will be responsible for the costs of this treatment.
- Transportation by chair car or wheelchair van is not covered.

Extended Care

In an extended care facility (skilled nursing facility, rehabilitation hospital, or chronic hospital) for:

- skilled nursing services;
- chronic disease services; or
- rehabilitative services.

Prior approval by an *Authorized Reviewer* is required at both the *In-Network* and *Out-of-Network Levels of Benefits.* See "Important Notes" on page 39 of this Navigator *Member Handbook* for more information about when you are responsible for obtaining this approval.

Note: Covered facility and physician services for Extended Care provided in a skilled nursing facility are limited to a total of 45 days per *Member* in a *calendar year* (*In-Network* and *Out-of-Network Levels* combined).

Other Health Services – continued

Home health care
(must be approved by an *Authorized Reviewer*)

Coverage is provided for the following services for *Members* who are homebound*:

Home health care services provided by an accredited home health agency under a physician's written order, including:

- home visits by a *Tufts HP* physician;
- inhalation therapy;
- infusion therapy;
- total parenteral nutritional therapy;
- skilled nursing care and physical therapy; and
- the following services, if determined to be a *Medically Necessary* component of skilled nursing or physical therapy:
  - speech therapy,
  - occupational therapy,
  - medical/psychiatric social work,
  - nutritional consultation,
  - the use of *Durable Medical Equipment*, and
  - the services of a part-time home health aide.

*To be considered homebound, you do not have to be bedridden. However, your condition should be such that there exists a usual inability to leave the home and, consequently, leaving the home would require a considerable and taxing effort. If you leave the home, you may be considered homebound if the absences from the home are infrequent or for periods of relatively short duration, or to receive medical treatment.

Notes:

- Home health care services for physical and occupational therapies following an injury or illness are only covered to the extent that those services are provided to restore function lost or impaired, as described under "Short term physical and occupational services" on page 45. However, those home health care services are not subject to the 90-day limit listed under "Short term physical and occupational services".
- The *Plan* also covers *Durable Medical Equipment* in connection with home health care services. For coverage information, see "Medical Appliances and Equipment" on page 52.

Hospice care services

The *Plan* will cover the following services for *Members* (having a life expectancy of 6 months or less):

- physician services;
- nursing care provided by or supervised by a registered professional nurse;
- social work services;
- volunteer services; and
- counseling services (including bereavement counseling services for the *Member's* family or a primary care person for up to one year following the *Member's* death).

"Hospice care services" are defined as a coordinated licensed program of services provided, during the life of the *Member*, to a terminally ill *Member*. Such services can be provided:

- in a home setting;
- on an *Outpatient* basis; and
- on a short-term *Inpatient* basis, for the control of pain and management of acute and severe clinical problems which cannot, for medical reasons, be managed in a home setting.

Other Health Services – continued

Injectable medications

Coverage is provided for injectable medications that are required for and are an essential part of an office visit to diagnose and treat illness or injury. *Medically Necessary* hypodermic needles and syringes required to inject these medications are also covered.

Notes:

- Prior authorization and dispensing limits may apply.
- Medications that are listed on the *Tufts HP* Web site as covered under a *Tufts HP* pharmacy benefit are not covered under this "Injectable medications" benefit.

Medical Appliances and Equipment

- *Durable Medical Equipment*

  Equipment must meet the following definition of "*Durable Medical Equipment*."

  Durable Medical Equipment is a device or instrument of a durable nature that:
  - is reasonable and necessary to sustain a minimum threshold of independent daily living;
  - is made primarily to serve a medical purpose;
  - is not useful in the absence of illness or injury;
  - can withstand repeated use; and
  - can be used in the home.

  In order to be eligible for coverage, the equipment must also be the most appropriate available supply or level of service for the *Member* in question considering potential benefits and harms to that individual.

  Equipment that *Tufts Health Plan* determines to be non-medical in nature and used primarily for non-medical purposes (even though that equipment may have some limited medical use) will not be considered *Durable Medical Equipment* and will not be covered under this benefit.

  Important Note: You may be responsible for paying towards the cost of *Durable Medical Equipment* covered at the *Out-of-Network Level of Benefits*. To determine whether your *Durable Medical Equipment* benefit is subject to a *Deductible*, *Coinsurance*, or a benefit limit at the *Out-of-Network Level of Benefits*, please see the "Benefit Overview" and "Benefit Limits" sections earlier in this *Member Handbook* or call Member Services.

  The following examples of covered and non-covered items are for illustration only. Please call Member Services with questions about whether a particular piece of equipment is covered.

  Below are examples of covered items (this list is not all-inclusive):

  - *Prosthetic Devices* (such as artificial legs, arms, eyes, or breasts);
  - orthotic devices (such as knee and back braces); and
  - blood glucose monitors, including voice synthesizers for blood glucose monitors for use by the legally blind;
  - oral appliances for the treatment of sleep apnea;
  - equipment such as hospital beds, wheelchairs, power/electric wheelchairs, crutches, walkers, and devices that extract oxygen from the air (for example, oxygen concentrators).

  Tufts Health Plan will decide whether to purchase or rent the equipment for you. This equipment must be purchased or rented from a *Durable Medical Equipment Provider* that has an agreement with *Tufts Health Plan* to provide such equipment.

Other Health Services – continued

Medical Appliances and Equipment, continued

Below are examples of excluded items (this list is not all-inclusive):

- air conditioners or air purifiers;
- any type of thermal therapy device;
- articles of special clothing, except for gradient pressure support aids for lymphedema or venous disease and clothing necessary to wear a covered device (e.g., mastectomy bras and stump socks);
- bed-related items, including, but not limited to, bed trays, bed pans, over-the-bed tables, and bed wedges;
- car/van modifications;
- comfort or convenience devices;
- dehumidifiers;
- dentures;
- exercise equipment;
- fixtures to real property: ceiling lifts, elevators, ramps, stair climbers;
- foot orthotics and arch supports, except for therapeutic/molded shoes and shoe inserts for a *Member* with severe diabetic foot disease;
- heating pads;
- hot tubs, jacuzzis, shower chairs, swimming pools, or whirlpools;
- hot water bottles;
- manual breast pumps;
- mattresses, except for mattresses used in conjunction with a hospital bed and ordered by a physician. Commercially available standard mattresses (e.g., Tempur-Pedic® or Posturepedic® mattresses), even if used in conjunction with a hospital bed, are not covered;
- saunas; or
- self-monitoring devices, except for certain devices that *Tufts Health Plan* determines would provide a *Member* with the ability to detect or prevent the onset of a sudden life-threatening condition.

Notes:

- Prosthetic devices and certain *Durable Medical Equipment* may require *Authorized Reviewer* approval at both the *In-Network* and *Out-of-Network Levels of Benefits*. See "Important Notes" on page 39 for more information about when you are responsible for obtaining this approval.) Please note that breast prostheses provided in connection with a mastectomy do not require the prior approval of an *Authorized Reviewer.* Contact the Member Services Department with coverage questions.
- Coverage for breast prostheses and prosthetic arms and legs (in whole or in part) includes coverage for the cost of repairs. For breast prostheses and prosthetic arms and legs, coverage is provided for the most appropriate *Medically Necessary* model.

- Other Medical Appliances and Equipment

  - The first pair of eyeglass lenses (eyeglass frames are not covered) or contact lenses following cataract surgery.

  - Contact lenses, including the fitting of the lenses, when required to treat keratoconus.

  - Hearing aids, including the fitting of the hearing aid, are covered when prescribed by a physician and obtained from a hearing aid supplier.

    When there is a pathological change in the *Member's* hearing or the hearing aid is lost, benefits for a replacement hearing aid are also covered subject to the benefit maximum.

    Note: Coverage for hearing aids is limited to a maximum benefit of $1,700 per *Member* in each 24-month period. Covered in full up to the first $500. Then, the *Plan* pays 80% of the next $1,500 (*In-Network* and *Out-of-Network Levels* combined); the *Member* is responsible for paying 20% of the $1,500 (plus any balance). Over-the-counter replacement hearing aid batteries are not covered.

Other Health Services -- continued

Personal Emergency Response Systems (PERS)

Covered Services are provided only for installation and rental charges for a hospital-based Personal Emergency Response System when:

- the system is used as an alternative to reduce or divert *Inpatient* admissions;
- the patient is homebound and medically at risk, as determined by *Tufts Health Plan*; and
- the patient is alone for at least four (4) hours each day, five (5) days a week and is functionally impaired.

Covered Services do not include the purchase of a Personal Emergency Response System.

Note: Covered PERS benefits are limited to a total of $50 per *Member* for installation charges and $40 per *Member* each month for rental of the system. The Navigator Plan pays 80% of the charges up to these maximum allowed installation and rental charges. You are responsible for paying the remaining 20% of those charges, as well as any additional fees or charges for the system.

Private Duty Nursing

- *Inpatient* private duty nursing services qualify as *Covered Services* when:
  - the frequency and complexity of the skilled nursing care is such that the health care facility's regular nursing staff could not perform the services;
  - the *Member* is a Hospital *Inpatient* for the treatment of a medical condition; and
  - the services are *Medically Necessary*, as determined by *Tufts Health Plan*.

- Private duty nursing services provided in the *Member's* home qualify as *Covered Services* when:
  - the frequency and complexity of the skilled nursing care is such that the administration of treatment and the evaluation of the patient's response to the treatment require the skills of a registered nurse; and
  - the services are *Medically Necessary*, as determined by *Tufts Health Plan;* and
  - the services are approved by an *Authorized Reviewer*.

Note: Any combination of Covered private duty nursing services (whether as an *Inpatient* or at home) are limited to a total of $8,000 per *Member* in a *calendar year* (*In-Network* and *Out-of-Network Levels* combined).

Scalp Hair Prostheses or Wigs

Coverage is provided for:

- scalp hair prostheses made specifically for an individual, or a wig, and provided for hair loss due to alopecia areata, alopecia totalis, or permanent loss of scalp hair due to injury.
- scalp hair prostheses or wigs worn for hair loss suffered as a result of the treatment of any form of cancer or leukemia.

Note: *Covered Services* for these prostheses and wigs are limited to a total of $350 per *Member* in a *calendar year* (*In-Network* and *Out-of-Network Levels* combined).

Special medical formulas

Included in this benefit are the following: special medical formulas; nonprescription enteral formulas; and low protein foods, when prescribed by a physician for the treatments described below:

Low protein foods:

When given to treat inherited diseases of amino acids and organic acids.

Note: Covered up to a maximum benefit of $2,500 per *calendar year* (*In-Network* and *Out-of-Network Levels* combined).

Other Health Services -- continued

Nonprescription enteral formulas (prior approval by an *Authorized Reviewer* may be required)

- For home use for treatment of malabsorption caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction, and inherited diseases of amino acids and organic acids.
- When *Medically Necessary*: infant formula for milk or soy protein intolerance; formula for premature infants; and supplemental formulas for growth failure.

Note: Services may require prior approval by an *Authorized Reviewer* at both the *In-Network* and *Out-of-Network Levels of Benefits*. See "Important Notes" on page 39 for more information about when you are responsible for obtaining this approval.

Special medical formulas (prior approval by an *Authorized Reviewer* may be required)

- For the treatment of phenylketonuria, tyrosinemia, homocystinuria, maple syrup urine disease, propionic acidemia, and methylmaloric acidemia; or
- when *Medically Necessary*, to protect the unborn fetuses of women with PKU.

Note: Services may require prior approval by an *Authorized Reviewer* at both the *In-Network* and *Out-of-Network Levels of Benefits*. See "Important Notes" on page 39 for more information about when you are responsible for obtaining this approval.

Spinal manipulation

Spinal manipulation, when provided by a chiropractor.

Note: Benefits for *Covered* spinal manipulation services are limited to one spinal manipulation evaluation and a total of 20 visits per *Member* in a *calendar year* (*In-Network* and *Out-of-Network Levels* combined). Spinal manipulation services for *Members* age 12 and under are not covered.

Prescription Drug Benefit

Introduction

This section describes the prescription drug benefit. The following topics are included in this section to explain your prescription drug coverage:

- How Prescription Drugs Are Covered
- Prescription Drug Coverage Table
- What is Covered
- What is Not Covered
- *Tufts HP* Pharmacy Management Programs
- Filling Your Prescription

How Prescription Drugs Are Covered

Prescription drugs will be considered *Covered Services* only if they comply with the *Tufts Health Plan* Pharmacy Management Programs section described below and are:

- listed below under *What is Covered*;
- provided to treat an injury, illness, or pregnancy; and
- *Medically Necessary*.

For a current list of covered drugs, please go to *Tufts Health Plan's* Web site at **www.tuftshealthplan.com**, or call the Member Services Department. For a list of non-covered drugs, please see Part 10 (pages 83-88).

PRESCRIPTION DRUG COVERAGE TABLE	
Description	**Coverage**
DRUGS OBTAINED AT A RETAIL PHARMACY: Covered prescription drugs (including both acute and maintenance drugs), when you obtain them directly from a *Tufts HP* designated retail pharmacy.	**Tier-1 drugs (many generic drugs are on Tier-1):** $10 *Copayment* for up to a 30-day supply **Tier-2 drugs:** $20 *Copayment* for up to a 30-day supply **Tier-3 drugs:** $40 *Copayment* for up to a 30-day supply
DRUGS OBTAINED THROUGH A MAIL SERVICES PHARMACY: Most maintenance medications, when mailed to you through the *Tufts HP* designated mail services pharmacy.	**Tier-1 drugs (many generic drugs are on Tier-1):** $20 *Copayment* for up to a 90-day supply **Tier-2 drugs:** $40 *Copayment* for up to a 90-day supply **Tier-3 drugs:** $90 *Copayment* for up to a 90-day supply
Important Note: When your physician prescribes a brand-name drug that has a generic equivalent, in Massachusetts and many other states you will receive the generic drug and pay the applicable Tier *Copayment.* However, regardless of where you fill your prescription, if your physician requests that you receive the covered brand-name drug only, you will pay the *Copayment* applicable to the generic drug plus the difference between the cost of the generic drug and the cost of the covered brand-name drug. Please note that in most cases, there may be a significant difference in price between the brand-name drug and the generic drug, resulting in a significant difference in what you are required to pay.	

Prescription Drug Benefit, continued

What is Covered

The Navigator Plan covers the following under this Prescription Drug Benefit:

- Prescribed drugs (including hormone replacement therapy for peri and post-menopausal women) that by law require a prescription and are not listed under "What is Not Covered" (see "Important Notes" later in this Prescription Drug Benefit).
- Insulin, insulin pens, insulin needles and syringes; lancets; blood glucose, urine glucose, and ketone monitoring strips; and oral diabetes medications that influence blood sugar levels.
- Acne medications for individuals through the age of 25.
- Oral contraceptives, diaphragms, and other hormonal contraceptives (e.g., patches, rings) that require a prescription by law*.

  *Note: This Prescription Drug Benefit only describes contraceptive coverage for oral contraceptives, diaphragms, and other hormonal contraceptives (e.g., patches, rings) that require a prescription by law. See "Family Planning" on page 41 of this Navigator *Member Handbook* for information about other contraceptive drugs and devices that qualify as *Covered Services*.
- Fluoride for *Children*.
- Injectables and biological serum, except as covered under "Injectable medications" on page 52. *Medically Necessary* hypodermic needles and syringes required to inject these medications are also covered.
- Prefilled sodium chloride for inhalation (both prescription and over-the-counter).
- Off-label use of FDA-approved prescription drugs used in the treatment of cancer or HIV/AIDS which have not been approved by the FDA for that indication, provided, however, that such a drug is recognized for such treatment:
  - in one of the standard reference compendia;
  - in the medical literature; or
  - by the Commissioner of Insurance.
- Compounded medications, if at least one active ingredient requires a prescription by law.
- Over-the-counter drugs included in the list of covered drugs on the *Tufts HP* Web site.

Note: Certain prescription drug products may be subject to one of the ***Tufts Health Plan* Pharmacy Management Programs** described below.

Prescription Drug Benefit, Continued

What is Not Covered

The Navigator Plan does not cover the following under this Prescription Drug Benefit:

- Prescription and over-the-counter homeopathic medications.
- Drugs that by law do not require a prescription (unless listed as covered in the "What is Covered" section above).
- Drugs that are listed in Part 10 (see pages 83-88).
- Vitamins and dietary supplements (except prescription prenatal vitamins and fluoride for *Children*).
- Topical and oral fluorides for adults.
- Medications for the treatment for idiopathic short stature.
- Cervical caps, IUDs, implantable contraceptives (e.g., Implanon® (etonorgestrel), levonorgestrel implants), Depo-Provera or its generic equivalent, (these are covered under your *Outpatient* care benefit earlier in Part 5 – see "Family Planning Procedures, Services, and Contraceptives" on page 41).
- Experimental drugs: drugs that cannot be marketed lawfully without the approval of the FDA and such approval has not been granted at the time of their use or proposed use or such approval has been withdrawn.
- Non-drug products such as therapeutic or other *Prosthetic Devices*, appliances, supports, or other non-medical products. These may be provided as described earlier in Part 5 (see "Medical Appliances and Equipment" on page 52).
- Immunization agents. These may be provided under "Preventive health care" (see page 44).
- Prescriptions filled at pharmacies other than *Tufts Health Plan* designated pharmacies, except for *Emergency* care.
- Smoking cessation agents.
- Drugs for asymptomatic onchomycosis, except for *Members* with diabetes, vascular compromise, or immune deficiency status.
- Acne medications for individuals 26 years of age or older, unless *Medically Necessary*.
- Drugs which are dispensed in an amount or dosage that exceeds *Tufts Health Plan's* established dispensing limitations.
- Compounded medications, if no active ingredients require a prescription by law.
- Prescriptions filled through an internet pharmacy that is not a Verified Internet Pharmacy Practice Site certified by the National Association of Boards of Pharmacy.
- Prescription medications once they become available over-the-counter. In this case, the specific medication may not be covered and the entire class of prescription medications may also not be covered.
- Prescription medications when packaged with non-prescription products.

Prescription Drug Benefit, Continued

Tufts Health Plan Pharmacy Management Programs

In order to provide safe, clinically appropriate, cost-effective medications under this Prescription Drug Benefit, *Tufts Health Plan* has developed the following Pharmacy Management Programs:

Dispensing Limitations Program:

Tufts Health Plan limits the quantity of selected medications that *Members* can receive in a given time period, for cost, safety and/or clinical reasons.

Prior Authorization Program:

Tufts Health Plan restricts the coverage of certain drug products that have a narrow indication for usage, may have safety concerns and/or are extremely expensive, requiring the prescribing physician to obtain prior approval from *Tufts Health Plan* for such drugs.

Special Designated Pharmacy Program (Mail Order):

Tufts Health Plan has designated special pharmacies to supply a select number of medications via mail order, including medications used in the treatment of infertility, multiple sclerosis, hemophilia, hepatitis C, growth hormone deficiency, rheumatoid arthritis, and cancers treated with oral medications. These pharmacies specialize in providing medications used to treat certain conditions, and are staffed with clinicians to provide support services to *Members*. Medications may be added to this program from time to time. Special pharmacies can dispense up to a 30-day supply of medication at one time via mail order.

Non-Covered Drugs With Suggested Alternatives:

While *Tufts Health Plan* covers over 4,500 drugs, a small number of drugs (less than 1%) are not covered because there are safe, effective and more affordable alternatives available. These non-covered drugs are listed in Part 10 (see pages 83-88). All of the alternative drug products are approved by the U.S. Food and Drug Administration (FDA) and are widely used and accepted in the medical community to treat the same conditions as the medications that are not covered.

New-To-Market Drug Evaluation Process:

Tufts Health Plan's Pharmacy and Therapeutics Committee reviews new-to-market drug products for safety, clinical effectiveness and cost. *Tufts Health Plan* then makes a coverage determination based on the Pharmacy and Therapeutics Committee's recommendation.

A new drug product will not be covered until this process is completed – usually within 6 months of the drug product's availability.

IMPORTANT NOTES:

- If your physician feels it is *Medically Necessary* for you to take medications that are restricted under any of the ***Tufts Health Plan* Pharmacy Management Programs** described above, he or she may submit a request for coverage. *Tufts Health Plan* will approve the request if it meets the guidelines for coverage. For more information, call the Member Services Department.
- The *Tufts Health Plan* Web site has a list of covered drugs with their tiers. *Tufts Health Plan* may change a drug's tier during the year. For example, if a brand drug's patent expires, *Tufts Health Plan* may change the drug's status by either (a) moving the brand drug from Tier-2 to Tier-3 or (b) moving the brand drug to the list of non-covered drugs in Part 10 (see pages 83-88) when the generic drug becomes available. Many generic drugs are available on Tier-1.
- If you have questions about your prescription drug benefit, would like to know the tier of a particular drug, or would like to know if your medication is part of a Pharmacy Management Program, check *Tufts Health Plan's* Web site at **www.tuftshealthplan.com**, or call the Member Services Department.

Filling Your Prescription

Where to Fill Prescriptions:

You can fill your prescriptions at any *Tufts Health Plan* designated pharmacy. *Tufts Health Plan* designated pharmacies include:

- for the majority of prescriptions, many of the pharmacies in Massachusetts and additional pharmacies nationwide; and
- for a select number of drug products, a small number of special designated pharmacy providers. (For more information about *Tufts Health Plan's* special designated pharmacy program, see ***Tufts Health Plan* Pharmacy Management Programs** earlier in this Prescription Drug Benefit section.) If you have questions about where to fill your prescription, call the Member Services Department.

How to Fill Prescriptions:

- When you fill a prescription, provide your member ID card to any *Tufts Health Plan* designated pharmacy and pay your *Copayment.*
- If the cost of your prescription is less than your *Copayment*, then you are only responsible for the actual cost of the prescription.
- If you have any problems using this benefit at a *Tufts Health Plan* designated pharmacy, call the Member Services Department.

- Important: Your prescription drug benefit will only be honored at a *Tufts Health Plan* designated pharmacy. In cases of *Emergency*, please call the Member Services Department at 1-800-870-9488 for instructions about submitting your prescription drug claims for reimbursement.

Filling Prescriptions for Maintenance Medications:

If you are required to take a *maintenance* medication, *Tufts HP* offers you two choices for filling your prescription:

- you may obtain your maintenance medication directly from a *Tufts HP* designated retail pharmacy for up to a 30-day supply; or
- you may have most maintenance medications* mailed to you through a *Tufts HP* designated mail services pharmacy.

*The following may not be available to you through a *Tufts HP* designated mail services pharmacy:

- medications for short term medical conditions;
- certain controlled substances and other prescribed drugs that may be subject to exclusions or restrictions;
- medications that are part of *Tufts HP's* Dispensing Limitations program; or
- medications that are part of *Tufts HP's* Special Designated Pharmacy program.

NOTE: Your *Copayments* for covered prescription drugs are shown in the Prescription Drug Coverage Table earlier in this section.

Exclusions from Benefits

The *Plan* or Navigator does not cover the following services, supplies, or medications:

- A service, supply or medication that is not *Medically Necessary*, as determined by *Tufts Health Plan*.
- A service, supply or medication that is not a *Covered Service*.
- A service, supply or medication that is not essential to treat an injury, illness, or pregnancy, except for preventive care services.
- A service, supply, or medication if there is a less intensive level of service, supply, or medication or more cost-effective alternative which can be safely and effectively provided, or if the service, supply, or medication can be safely and effectively provided in a less intensive setting.
- A service, supply, or medication that is primarily for personal comfort or convenience.
- *Custodial Care*.
- Services related to non-*covered services*.
- Charges for missed appointments that you do not cancel in advance, if the *Provider's* office policy is to charge for such appointments.
- A drug, device, medical treatment or procedure (collectively "treatment") that is *Experimental or Investigative*.

  This exclusion does not apply to the following services or medications when they meet the requirements of Massachusetts law:
  - bone marrow transplants for breast cancer;
  - patient care services provided as part of a qualified clinical trial (for the treatment of cancer); or
  - Off-label uses of prescription drugs for the treatment of cancer or HIV/AIDS

  If the treatment is *Experimental or Investigative*, the Navigator Plan will not pay for any related treatments that are provided to the *Member* for the purpose of furnishing the *Experimental or Investigative* treatment.
- Drugs, medicines, materials or supplies for use outside the hospital or any other facility, except as described earlier in this Part 5. Medications and other products which can be purchased without a prescription, except those listed as covered earlier in Part 5.
- Services provided by a relative (by blood or marriage) or friend unless the relative or friend is a *Tufts HP Provider*. If the *Member* is a *Tufts HP Provider*, the *Member* cannot provide or authorize services for himself or herself or a member of his or her immediate family (by blood or marriage).
- Services, supplies, or medications required by a third party which are not otherwise *Medically Necessary*. Examples of a third party are an employer, an insurance company, a school or a court.
- Services for which the *Member* is not legally obligated to pay or services for which no charge would be made if the *Member* had no health plan.
- Care for conditions for which benefits are available under workers' compensation or other government programs other than Medicaid.
- Care for conditions that state or local law requires to be treated in a public facility.
- Any additional fee a *Provider* may charge as a condition of access or any amenities that access fee is represented to cover. Refer to the *Directory of Health Care Providers* to determine if your *Provider* charges such a fee.

Exclusions from Benefits, Continued

- Charges incurred when the *Member*, for his or her convenience, chooses to remain an *Inpatient* beyond the discharge hour.
- Facility charges or related services if the procedure being performed is not a *Covered Service*.
- Dental care and treatment, except as provided under "Oral Health Services" on page 45. Examples of excluded services include: preventive dental care; periodontal treatment; endodontics; alteration of teeth; care related to deciduous (baby) teeth; restorative services (including, but not limited to, crowns, fillings, root canals), and bondings; splints and oral appliances (except for sleep apnea, as described in "Medical Appliances and Equipment" on page 52), including those for TMJ disorders; TMJ disorder related therapies, including TMJ appliances, occlusal adjustment, and TMJ appliance-related therapies; orthodontia, even when it is an adjunct to other medical and surgical procedures; dentures; dental supplies.
- Surgical removal or extraction of teeth, except as provided under "Oral health services" on page 45.
- Cosmetic (meaning to change or improve appearance) surgery, procedures, supplies, medications or appliances, except as provided under "Reconstructive surgery and procedures" on page 49.
- Rhinoplasty, except as provided under "Reconstructive surgery and procedures" on page 49; liposuction; and brachioplasty.
- Treatment of spider veins; removal or destruction of skin tags; treatment of vitiligo.
- Hair removal, except when *Medically Necessary* to treat an underlying skin condition.
- Costs associated with home births; costs associated with the services provided by a doula.
- Circumcisions performed in any setting other than a hospital, *Day Surgery* facility, or a physician's office.
- Infertility services for *Members* who do not meet the definition of Infertility as described in the "*Outpatient* Care" section on page 40; experimental infertility procedures; the costs of surrogacy; reversal of voluntary sterilization; long-term (longer than 90 days unless the *Member* is in active infertility treatment) sperm or embryo cryopreservation not associated with active infertility treatment; and infertility services which are necessary for conception as a result of voluntary sterilization or following an unsuccessful reversal of a voluntary sterilization; donor sperm and associated laboratory services in the absence of diagnosed male factor infertility in the partner; costs associated with donor recruitment and compensation.
  Note: *Tufts HP* may authorized short-term (less than 90 days) cryopreservation of sperm or embryos for certain medical conditions that may impact a *Member's* future fertility. Prior approval by an *Authorized Reviewer* is required
- Drugs for anonymous or designated egg donors that are directly related to a stimulated Assisted Reproductive Technology (ART) cycle, unless the ART service has been approved by an *Authorized Reviewer* and the *Member* is the sole recipient of the donor's eggs.
- Treatments, medications, procedures, services and supplies related to: medical or surgical procedures for sexual reassignment; reversal of voluntary sterilization; or over-the-counter contraceptive agents.
- Human organ transplants, except as described on page 47. Expenses for transportation and lodging in connection with human organ transplants are not covered.
- Services provided to a non-*Member*, except as described earlier in Part 5:
  - for organ donor charges under "Human organ transplants" (see page 47);
  - for bereavement counseling services under "Hospice care services" (see page 51);
  - the costs of procurement and processing of donor sperm, eggs, or embryos under "Infertility services" (to the extent such costs are not covered by the donor's health coverage, if any).
- Acupuncture; biofeedback, except for the treatment of urinary incontinence; hypnotherapy; psychoanalysis; TENS units or other neuromuscular stimulators and related supplies; electrolysis; chiropractic services, except as described in " Spinal manipulation" on page 55; spinal manipulation services for *Members* age 12 and under; any type of thermal therapy device; *Inpatient* and *Outpatient* weight-loss programs and clinics; exercise classes; relaxation therapies; massage therapies, except as described under "Short term physical and occupational therapy services" earlier in this chapter; services by a personal trainer; cognitive rehabilitation programs; cognitive retraining programs. Also excluded are diagnostic services related to any of these procedures or programs.

Exclusions from Benefits, Continued

- All alternative, holistic, naturopathic, and/or functional health medicine services, supplies or procedures, and all services, procedures, labs and supplements associated with this type of medicine.

- Any service, supply, or procedure performed in a non-conventional setting (including, but not limited to, spas/resorts, therapeutic programs, and camps).

- Blood, blood donor fees, blood storage fees, blood substitutes, blood banking, cord blood banking, and blood products, except as detailed in the "Note" below.

  Note: The following blood services and products are covered:

  - blood processing;
  - blood administration;
  - Factor products (monoclonal and recombinant) for Factor VIII deficiency (classic hemophilia), Factor IX deficiency (Christmas factor deficiency), and von Willebrand disease (prior approval by an *Authorized Reviewer* is required);
  - Intravenous immunoglobulin for treatment of severe immune disorders, certain neurological conditions, infectious conditions, and bleeding disorders (prior approval by an *Authorized Reviewer* is required).

- Devices and procedures intended to reduce snoring including, but not limited to, laser-assisted uvulopalatoplasty, somnoplasty, and snore guards.

- Examinations, evaluations or services for educational or developmental purposes, including physical therapy, speech therapy, and occupational therapy, except as provided earlier in Part 5. Vocational rehabilitation services and vocational retraining. Also services to treat learning disabilities, behavioral problems, and developmental delays and services to treat speech, hearing and language disorders in a school-based setting. The term "developmental" refers to a delay in the expected achievement of age-appropriate fine motor, gross motor, social, or language milestones that is not caused by an underlying medical illness or condition.

- Eyeglasses, lenses or frames; or refractive eye surgery (including radial keratotomy) for conditions which can be corrected by means other than surgery. Except as described in "Medical Appliances and Equipment" on page 52, the Navigator Plan will not pay for eyeglasses, contact lenses or contact lens fittings.

- Hearing aids or hearing aid fittings, except as described under "Medical Appliances and Equipment" on page 52.

- Routine foot care, such as: trimming of corns and calluses; treatment of flat feet or partial dislocations in the feet; orthopedic shoes and related items that are not part of a brace; foot orthotics or fittings; or casting and other services related to foot orthotics or other support devices for the feet. The exclusion for routine foot care does not apply to *Members* diagnosed with diabetes.

  Note: This exclusion does not apply to therapeutic/molded shoes and shoe inserts for a *Member* with severe diabetic foot disease when the need for therapeutic shoes and inserts has been certified by the *Member's* treating doctor, and the shoes and inserts:

  - are prescribed by a *Provider* who is a podiatrist or other qualified doctor; and
  - are furnished by a *Provider* who is a podiatrist, orthotist, prosthetist, or pedorthist.

- Transportation, including transportation by chair car, wheelchair van, or taxi, except as described in "Ambulance services" on page 50; lodging related to receiving any medical service.

Overview

Introduction
This section contains information about federal continuation coverage, continuation coverage after the *Subscriber* dies, and *Nongroup Coverage*.

GROUP HEALTH CONTINUATION COVERAGE UNDER COBRA

You are receiving this notice because you are covered under the *Group Insurance Commission's* (*GIC's*) health benefits program. This notice contains important information about your right to continue group health coverage at COBRA group rates if your group coverage otherwise would end due to certain life events. Please read it carefully.

WHAT IS COBRA COVERAGE? COBRA is a federal law under which certain former employees, retirees, *Spouses*, former *Spouses* and *Dependent Children* have the right to temporarily continue their existing group health coverage at group rates when group coverage otherwise would end due to certain life events, called 'Qualifying Events.' If you elect COBRA coverage, you are entitled to the same coverage being provided under the *GIC's* plan to similarly situated employees or *Dependents*. The *GIC* administers COBRA coverage.

This notice explains your COBRA rights and what you need to do to protect your right to receive it. If you have questions about COBRA coverage, contact the *GIC's* Public Information Unit at 617-727-2301, ext. 1 or write to the Unit at P.O. Box 8747, Boston, MA 02114. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration's website at **www.dol.gov/ebsa**.

WHO IS ELIGIBLE FOR COBRA COVERAGE? Each individual entitled to COBRA (known as a "Qualified Beneficiary") has an *independent right* to elect the coverage, regardless of whether or not other eligible family *members* elect it. Qualified Beneficiaries may elect to continue their group coverage that otherwise would end due to the following life events:

If you are an employee covered by the *GIC's* Health benefits program, you have the right to choose COBRA coverage if

- You lose your group health coverage because your hours of employment are reduced; or
- Your employment ends for reasons other than gross misconduct.

If you are the *Spouse* of an employee covered by the *GIC's* health benefits program, you have the right to choose COBRA coverage for yourself if you lose *GIC* health coverage for any of the following reasons (known as "qualifying events"):

- Your *Spouse* dies;
- Your *Spouse's* employment with the Commonwealth, *Participating Municipality*, or other entity ends for any reason other than gross misconduct or his/her hours or employment are reduced; or
- You and your *Spouse* divorce, legally separate, or you or your former *Spouse* remarries.

If you have *Dependent Children* who are covered by the *GIC's* health benefits program, each *Child* has the right to elect COBRA coverage if he or she loses *GIC* health coverage for any of the following reasons (known as "qualifying events"):

- The employee-parent dies;
- The employee-parent's employment is terminated (for reasons other than gross misconduct) or the parent's hours or employment are reduced;
- The parents divorce or legally separate; or
- The *Dependent* ceases to be a *Dependent Child* (please see "When Coverage Ends" on page 38 for more information.

GROUP HEALTH CONTINUATION COVERAGE UNDER COBRA, continued

HOW LONG DOES COBRA COVERAGE LAST? By law, COBRA coverage must begin on the day immediately after your group health coverage otherwise would end. If your group coverage ends due to employment termination or reduction in employment hours, COBRA coverage may last for up to 18 months. If it ends due to any other qualifying events listed above, you may maintain COBRA coverage for up to 36 months.

If you have COBRA coverage due to employment termination or reduction in hours, your family members' COBRA coverage may be extended beyond the initial 18-month period up to a *total* of 36 months (as measured from the initial qualifying event) if a second qualifying event – the insured's death or divorce - occurs during the 18 months of COBRA coverage. **You must notify the *GIC* in writing within 60 days of the second qualifying event and before the 18-month COBRA period ends in order to extend the coverage**. Your COBRA coverage may be extended to a total of 29 months (as measured from the initial qualifying event) if any qualified beneficiary in your family receiving COBRA coverage is disabled during the first 60 days of your 18-month COBRA coverage. **You must provide the *GIC* with a copy of the Social Security Administration's disability determination within 60 days after you receive it and before your initial 18 month COBRA period ends in order to extend the coverage**.

COBRA coverage will end before the maximum coverage period ends if any of the following occurs:

- The COBRA cost is not paid ***in full*** when due (see section on paying for COBRA);
- You or another qualified beneficiary become covered under another group health plan that does not impose any pre-existing condition exclusion for the qualified beneficiary's pre-existing covered condition covered by COBRA benefits;
- You are no longer disabled as determined by the Social Security Administration (if your COBRA coverage was extended to 29 months due to disability);
- Your employer no longer provides group health coverage to any of its employees; or
- Any reason for which the *GIC* terminates a non-COBRA enrollee's coverage (such as fraud).

The *GIC* will notify you in writing if your COBRA coverage is to be terminated before the maximum coverage period ends. The *GIC* reserves the right to terminate your COBRA coverage retroactively if you are subsequently found to have been ineligible for coverage.

HOW AND WHEN DO I ELECT COBRA COVERAGE? Qualified beneficiaries must elect COBRA coverage within 60 days of the date that their group coverage otherwise would end or within 60 days of receiving a COBRA notice, whichever is later. A qualified beneficiary may change a prior rejection of COBRA election any time until that date. **If you do not elect COBRA coverage within the 60–day election period, you will lose all rights to COBRA coverage**.

There are several considerations when deciding whether to elect COBRA coverage. COBRA coverage can help you avoid incurring a coverage gap of more than 63 days, which under Federal law can cause you to lose your right to be exempt from pre-existing condition exclusions when you elect subsequent health plan coverage. If you have COBRA coverage for the maximum period available to you, it provides you the right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions. You also have special enrollment rights under federal law, including the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a *Spouse's* plan) within 30 days after your COBRA coverage ends.

HOW MUCH DOES COBRA COVERAGE COST? Under COBRA, you must pay 102% of the applicable cost of your COBRA coverage. If your COBRA coverage is extended to 29 months due to disability, your cost will increase to 150% of the applicable full cost rate for the additional 11 months of coverage. COBRA costs will change periodically.

GROUP HEALTH CONTINUATION COVERAGE UNDER COBRA, continued

HOW AND WHEN DO I PAY FOR COBRA COVERAGE? If you elect COBRA coverage, you must make your first payment for COBRA coverage within 45 days after the date you elect it. **If you do not make your first payment for COBRA coverage within the 45-day period, you will lose all COBRA coverage rights under the plan.**

Your first payment must cover the cost of COBRA coverage from the time your coverage would have ended up to the time you make the first payment. **Services cannot be covered until the *GIC* receives and processes this first payment, and you are responsible for making sure that the amount of your first payment is enough to cover this entire period**. After you make your first payment, you will be required to pay for COBRA coverage for each subsequent month of coverage. These periodic payments are due usually around the 15th of each month. The *GIC* will send monthly bills, specifying the due date for payment and the address to which payment is to be sent for COBRA coverage, but **you are responsible for paying for the coverage even if you do not receive a monthly statement**. Payments should be sent to the *GIC's* address on the bill.

After the first payment, you will have a 30-day grace period beyond the due date on each monthly bill in which to make your monthly payment. Your COBRA coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. **If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to COBRA coverage.**

CAN I ELECT OTHER HEALTH COVERAGE BESIDES COBRA? Yes. You have the right to enroll, within 31 days after coverage ends, in an individual health insurance 'conversion' policy with your current health plan without providing proof of insurability. The benefits provided under such a policy might not be identical to those provided through COBRA. You may exercise this right in lieu of electing COBRA coverage, or you may exercise this right after you have received the maximum COBRA coverage available to you.

YOUR COBRA COVERAGE RESPONSIBILITIES

- **You must inform the *GIC* of any address changes to preserve your COBRA rights.**
- **You must elect COBRA within 60 days from the date you receive a COBRA notice or would lose group coverage due to one of the qualifying events described above**. If you do not elect COBRA coverage within the 60-day limit, your group health benefits coverage will end and you will lose all rights to COBRA coverage.
- **You must make the first payment for COBRA coverage within 45 days after you elect COBRA.** If you do not make your first payment for the entire COBRA cost due within that 45-day period, you will lose all COBRA coverage rights.
- **You must pay the subsequent monthly cost for COBRA coverage in full by the end of the 30-day grace period after the due date on the bill**. If you do not make payment in full by the end of the 30-day grace period after the due date on the bill, your COBRA coverage will end.
- **You must inform the *GIC* within 60 days of the later of either (1) the date of any of the following, or (2) the date on which coverage would be lost because of any of the following events:**
  - The employee's job terminates or his/her hours are reduced;
  - The employee or former employee dies;
  - The employee divorces or legally separates;
  - The employee or employee's former *Spouse* remarries;
  - A covered *Child* loses his or her continued *Dependent* coverage (see "When Coverage Ends" on page 38);
  - The Social Security Administration determines that the employee or a covered family member is disabled; or
  - The Social Security Administration determines that the employee or a covered family member is no longer disabled.

If you do not inform the *GIC* of these events within the time period specified above, you will lose all rights to COBRA coverage. To notify the *GIC* of any of the above events within the 60 days for providing notice, send a letter to the Public Information Unit at *Group Insurance Commission*, P. O. Box 8747, Boston, MA 02114-8747.

Death of *Subscriber*

Continuation coverage for surviving *Spouse* and *Dependent Children*
If the event of the death of the *Subscriber*, the surviving *Spouse* and/or eligible *Dependent Children* may continue coverage under this health care program. In order to continue this coverage, the surviving covered *Members* must notify the *GIC*.

The Uniformed Services Employment and Reemployment Rights Act (USERRA)

The Uniformed Services Employment and Reemployment Rights Act (USERRA) protects the rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services. The *GIC* has more generous guidelines for benefit coverage that apply to persons subject to USERRA as set forth below:

- If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your *Dependents* while in the military.
- If you don't elect to continue coverage during your military service, you have the right to be reinstated to *GIC* health coverage when you are reemployed.
- Service members who elect to continue their *GIC* health coverage are requested to pay the employee share for such coverage.
- USERRA coverage runs concurrently with COBRA and other state continuation coverage.
- The U.S. Department of Labor, Veterans' Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.

For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1-866-4-USA-DOL or visit its Web site at **www.dol.gov/vets**. If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice for representation. You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA. The rights listed here may vary depending on the circumstances.

For more information, please contact the *Commission.*

Coverage under an *Individual Contract*

If you live in Massachusetts:
If your *Group Insurance Commission* coverage ends, you may be eligible to enroll in *Nongroup Coverage* under an *Individual Contract* offered either directly by *Tufts Health Plan* or through the Commonwealth Health Insurance Connector Authority ("the Connector"). For more information, call Member Services or contact the Connector either by phone (1-877-MA-ENROLL) or on its Web site (**www.mahealthconnector.org**)

If you live outside Massachusetts:
If your *Group Insurance Commission* coverage ends, you are not eligible to enroll in coverage under an individual contract offered either directly by *Tufts Health Plan* or through the Commonwealth Health Insurance Connector Authority. Please contact your state insurance department for information about coverage options that are available to you in your state.

For more information
Please call Member Services.

Member Appeals Process

Tufts Health Plan ("*Tufts HP*") has a Member Satisfaction Process to address your concerns promptly. This process addresses:

- Internal Inquiry;
- Member Grievance Process; and
- Appeals:
  - Internal Member Appeals, and
  - Expedited Appeals.

All grievances and appeals should be sent to *Tufts HP* at the following address:

Tufts Health Plan
Navigator Plan
Attn: Appeals and Grievances Department
705 Mt. Auburn Street
P.O. Box 9193
Watertown, MA 02471-9193

All calls should be directed to the Member Services Department at **1-800-870-9488.**

Internal Inquiry
Call the Member Services Department to discuss concerns you may have regarding your health care. Every effort will be made to resolve your concerns. If your concerns cannot be explained or resolved, or if you tell a Member Specialist that you are not satisfied with the response with the response you have received from *Tufts HP,* we will notify you of any options you may have, including the right to have your inquiry processed as a grievance or appeal. If you choose to file a grievance or appeal, you will receive written acknowledgement and written resolution in accordance with the timelines outlined below.

Grievances
A grievance is a formal complaint about actions taken by *Tufts HP* or a *Tufts HP Provider.* There are two types of grievances: administrative grievances and clinical grievances. The two types of grievances are described below.

It is important that you contact *Tufts HP* as soon as possible to explain your concern. Grievances may be filed either verbally or in writing. If you choose to file a grievance verbally, please call a *Tufts HP* Member Specialist, who will document your concern and forward it to a Grievance Analyst in the Appeals and Grievances Department. To accurately reflect your concerns, you may want to put your grievance in writing and send it to the address provided at the beginning of this section. Your explanation should include:

- your name and address;
- your Member ID number;
- a detailed description of your concern (including relevant dates, any applicable medical information, and *Provider* names); and
- any supporting documentation.

Important Note: The *Member* Grievance Process does not apply to requests for a review of a denial of coverage. If you are seeking such a review, please see the "Internal *Member* Appeals" section below.

Administrative Grievance
An administrative grievance is a complaint about a *Tufts HP* employee, department, policy, or procedure, or about a billing issue.

Administrative Grievance Timeline

- If you file your grievance in writing, *Tufts HP* will notify you by mail, within five (5) business days after receiving your letter, that your letter has been received and provide you with the name, address, and telephone number of the Grievance Analyst coordinating the review of your grievance.
- If you file your grievance verbally, we will send you a written confirmation of our understanding of your concern within forty-eight (48) hours. We will also include the name, address, and telephone number of the person coordinating the review.
- *Tufts HP* will review your grievance and will send you a letter regarding the outcome within thirty (30) calendar days of receipt.
- The time limits in this process may be waived or extended upon mutual written agreement between you or your authorized representative and *Tufts HP.*

Clinical Grievances

A clinical grievance is a complaint about the quality of care or services that you have received from a *Tufts HP Provider*. If you have concerns about your medical care, you should discuss them directly with your *Provider.* If you are not satisfied with your *Provider's* response or do not wish to address your concerns directly with your *Provider,* you may contact Member Services to file a clinical grievance.

If you file your grievance in writing, we will notify you by mail, within five (5) business days after receiving your letter, that your letter has been received and provide you with the name, address, and telephone number of the Grievance Analyst coordinating the review of your grievance. If you file your grievance verbally, we will send you written confirmation of our understanding of your concerns within forty-eight (48) hours. We will also include the name, address, and telephone number of the person coordinating the review.

Tufts HP will review your grievance and will notify you in writing regarding the outcome, as allowed by law, within thirty (30) calendar days of receipt. The review period may be extended up to an additional thirty (30) days if additional time is needed to complete the review of your concern. You will be notified in writing if the review timeframe is extended.

Internal Member Appeals

Requests for coverage that was denied as specifically excluded in this Navigator *Member Handbook* (or subsequent updates) or for coverage that was denied based on *medical necessity* determinations are reviewed as appeals through *Tufts Health Plan's* Internal Appeals Process. Appeals do take into account personal situations to an extent; however, they are weighed against set benefits (for example, benefit limits and *Copayments*) as detailed in this *Member Handbook*. You may file a request yourself or you may designate someone to act on your behalf in writing. You have 180 days from the date you were notified of the denial of benefit coverage or claim payment to file your appeal.

(i) You can submit a verbal appeal of a benefit coverage decision to the Member Services Department, who will forward it to the Appeals and Grievances Department. You can also submit a written appeal to the address listed above under "Grievances". *Tufts HP* encourages you to submit your appeal in writing to accurately reflect your concerns. Your letter should include:

- your complete name and address;
- your ID number;
- a detailed description of your concern; and
- copies of any supporting documentation.

Internal Member Appeals, continued

(ii) Within five (5) business days following *Tufts Health Plan's* receipt of your written appeal, a *Tufts Health Plan* Appeals Analyst will send you an acknowledgment letter and, if appropriate, a request for authorization for the release of your medical and treatment information related to your appeal. Within 48 hours of receipt of a verbal appeal, a *Tufts Health Plan* Appeals Analyst will summarize your request for an appeal and send a copy to you. This summary will serve as the acknowledgment of receipt of your appeal and, if appropriate, will include a request for authorization for the release of related medical and treatment information.

Once you have signed and returned the authorization for the release of medical and treatment information to *Tufts Health Plan,* an Appeals Analyst will document the date of receipt and coordinate the investigation of your appeal. In the event that you do not sign and return the authorization for the release of medical and treatment information to *Tufts Health Plan* within thirty (30) calendar days of the day you requested a review of your case, *Tufts HP* may, in its discretion, issue a resolution of the appeal without reviewing some or all of your medical records.

(iii) The *Tufts Health Plan* Benefits Committee will review appeals concerning specific benefits and exclusions and make determinations. The *Tufts Health Plan* Appeals Committee will make utilization management (*medical necessity)* decisions. If your appeal involves an adverse determination (*medical necessity* determination), it will be reviewed by a medical director and/or a practitioner in the same or in a similar specialty that typically manages the medical condition, procedure, or treatment under review. The medical director and/or practitioner will not have previously reviewed your case.

(iv) The Appeals Analyst will notify you in writing of the Committee's decision within no more than thirty (30) calendar days of the receipt of your appeal. A copy of the decision will be sent to your physician, except in the case of Mental Health Appeals or if you request otherwise. A determination of claim denial will set forth:

- *Tufts Health Plan's* understanding of the request;
- the reason(s) for the denial;
- a specific reference to the contract provisions on which the denial is based; and
- a clinical rationale for the denial, if the appeal involves a *medical necessity* determination.

The decision letter for *medical necessity* determinations will also direct the *Member* to the Executive Director of the *GIC* for final appeal review and determination. Claim denials based upon the *Plan's* determination that the service is specifically excluded from coverage in this Navigator *Member Handbook* (or subsequent updates) are not appealable to the *GIC.*

Tufts Health Plan maintains records of each inquiry made by a *Member* or by that *Member's* designated representative.

Expedited Appeals
Tufts HP recognizes that there are circumstances that require a quicker turnaround than the thirty (30) calendar days allotted for the standard Appeals Process. *Tufts HP* will expedite an appeal when there is an ongoing service about to terminate or a service to be delivered imminently whereby a delay in treatment would seriously jeopardize your life and health or jeopardize your ability to regain maximum function. If your request does not meet the guidelines for an expedited appeal, *Tufts HP* will explain your right to use the standard appeals process.

If your request meets the guidelines for an expedited appeal, it will be reviewed by a medical director and/or practitioner in the same or in a similar specialty that typically manages the medical condition, procedure or treatment under review. The medical director and/or practitioner will not have previously reviewed your case.

Tufts HP will notify you by telephone within one business day after receiving the information necessary to conduct your appeal, but no later than 72 hours after *Tufts Health Plan's* receipt of the request.

If You Have Questions

If you have questions or need help submitting a grievance or an appeal, please call the Member Services Department for assistance.

Bills from *Providers*

Bills from *Providers*

Occasionally, you may receive a bill from a *Non-Network Provider* for *Covered Service*s. Before paying the bill, contact the *Tufts HP* Member Services Department.

If you do pay the bill, you must send the following information to the Member Reimbursement Medical Claims Department:

- a completed, signed Member Reimbursement Medical Claim Form, which can be obtained from the *Tufts HP* web site or by contacting the *Tufts HP* Member Services Department; and
- the documents listed on the Member Reimbursement Medical Claim Form that are required for proof of service and payment.

The address for the Member Reimbursement Medical Claims Department is listed on the Member Reimbursement Medical Claims Form.

Please note: You must contact *Tufts HP* regarding your bill(s) or send your bill(s) to *Tufts HP* within 24 months from the date of service. If you do not, the bill cannot be considered for payment.

If you receive *Covered Service*s from a *Non-Network Provider*, the *Plan* will pay up to the *Reasonable Charge* for the services. You are responsible for any amounts in excess of the *Reasonable Charge*, including the *Deductible*, *Coinsurance*, and/or *Copayments*.

The *Plan* reserves the right to be reimbursed by the *Member* for payments made due to *Tufts HP*'s error.

Limitation on Actions

You cannot file a lawsuit against either Navigator or *Tufts Health Plan* for any claim under this health care program more than two (2) years after the Navigator Plan denies the claim unless you do it within two (2) years from the time the cause of action arose.

Part 8 - Other *Plan* Provisions

Subrogation

The *Plan's* right of subrogation
Whether you are an enrolled *Subscriber* or *Dependent*, you may have a legal right to recover some or all of the costs of your health care from someone else; for example:
- your own or someone else's auto or homeowner's insurer; or
- the person who caused your illness or injury.

In that case, if the *Plan* pays or will pay for the costs of health care services provided to treat your illness or injury, it has the right to recover those costs in your name, with your consent, directly from that person or company. This is called the *Plan's* right of subrogation. This right has priority, except as otherwise provided by law. The *Plan* can recover against the total amount of any recovery, regardless of whether:

- all or part of the recovery is for medical expenses; or
- the recovery is less than the amount needed to reimburse you fully for the illness or injury.

Workers' compensation
Employers provide workers' compensation insurance for their employees to protect them in case of work-related illness or injury.

If you have a work-related illness or injury, you and your employer must ensure that all medical claims related to the illness or injury are billed to your employer's workers' compensation insurer. The *Plan* will not provide coverage for any injury or illness for which it determines that the *Member* is entitled to benefits pursuant to any workers' compensation statute or equivalent employer liability, or indemnification law (whether or not the employer has obtained workers' compensation coverage as required by law).

If the *Plan* pays for the costs of health care services or medications for any work-related illness or injury, the *Plan* has the right to recover those costs from you, the person, or company legally obligated to pay for such services, or from the *Provider.* If your *Provider* bills services or medications to the *Plan* for any work-related illness or injury, please contact the Liability and Recovery Department at 1-888-880-8699, x.1098.

The *Plan's* right of reimbursement
If you use your legal right to recover money by a lawsuit, settlement or otherwise, and you recover money, the *Plan* has the right to be reimbursed by you. In this case, you must repay the *Plan* for the cost of health care services, medications, and supplies that it paid or will pay, up to the total amount of your recovery.

Assignment of benefits
You hereby assign to the *Plan* any benefits you may be entitled to receive from a person or company that caused, or is legally responsible to reimburse you for your illness or injury. Your assignment is up to the cost of health care services and supplies, and expenses that the *Plan* paid or will pay for your illness or injury.

***Member* cooperation**

You agree:
- to notify the *Plan* of any events which may affect the *Plan's* rights of recovery under this section, such as
  - injury resulting from an automobile accident, or
  - job-related injuries that may be covered by workers' compensation;
- to cooperate with Navigator and *Tufts Health Plan* by
  - providing information and help, and
  - signing documents to help the Plan get reimbursed;
- that Navigator and *Tufts Health Plan* may
  - investigate,
  - request and release information which is necessary to carry out the purpose of this section, and
  - do the things Navigator and *Tufts Health Plan* decide are appropriate to protect the *Plan's* rights of recovery.

Subrogation Agent
Tufts Health Plan may contract with a third party to administer subrogation recoveries. In such case, that subcontractor will act as *Tufts Health Plan's* agent.

Coordination of Benefits

Benefits under other plans

You may have benefits under other plans for hospital, medical, dental or other health care expenses.

The Navigator Plan has a coordination of benefits program (COB) that prevents duplication of payment for the same health care services. We will coordinate benefits payable for *Covered Services* with benefits payable by other plans, consistent with state law.

Primary and secondary plans

The *Plan* will coordinate benefits by determining:

- which plan (Navigator or your other plans) has to pay first when you make a claim; and
- which plan (Navigator or your other plans) has to pay second.

These determinations will be made according to applicable state law and Division of Insurance regulations.

Right to receive and release necessary information

When you enroll in the *Plan*, you must include information on your membership application about other health coverage you have. After you enroll, you must notify *Tufts Health Plan* of new coverage or termination of other coverage. *Tufts Health Plan* may ask for and give out information needed to coordinate benefits.

You agree to provide information about other coverage and cooperate with *Tufts HP's* COB program.

Right to recover overpayment

The *Plan* may recover, from you or any other person or entity, any payments made that are greater than payments it should have made under the COB program. The *Plan* will recover only overpayments actually made.

For more information

For more information about COB, call the Liability and Recovery Department at 1-888-880-8699, x.1098.

Use and Disclosure of Medical Information

Use and disclosure of medical information

For information about how *Tufts Health Plan* uses and discloses your medical information, please contact the Member Services Department. Information is also available on the *Tufts Health Plan* Web site at **www.tuftshealthplan.com**.

For information about how the Commission uses and discloses your medical information, please contact the Commission.

Additional Plan Provisions

Tufts Health Plan and *Providers*

Tufts Health Plan arranges for health care services. *Tufts Health Plan* does not provide health care services. *Tufts Health Plan* has agreements with *Providers* practicing in their private offices throughout the *Service Area*. These *Providers* are independent. They are not Navigator's or *Tufts Health Plan's* employees, agents or representatives. *Providers* are not authorized to:

- change this *Member Handbook*; or
- assume or create any obligation for either Navigator or *Tufts Health Plan*.

Neither Navigator nor *Tufts Health Plan* is liable for any *Provider's* acts, omissions, representations, or other conduct

Acceptance of the terms of the Agreement

By enrolling in Navigator, *Subscribers* agree, on behalf of themselves and their enrolled *Dependents*, to all the terms and conditions of the Agreement between the *GIC* and *Tufts Health Plan*, including this *Member Handbook*.

Payments for coverage

Navigator is a self-funded plan. This means that the *GIC* is responsible for funding *Covered Services* for *Members* in accordance with the terms of the *Plan*.

Changes to this *Member Handbook*

The *GIC* may change this *Member Handbook*. Changes do not require any *Member's* consent. Notice of changes will be sent to *Subscribers* and will include the effective date of the change. The *Plan* is responsible for notifying you of changes. Changes will apply to all benefits for services received on or after the effective date.

Notice

Notice to *Members*: When *Tufts Health Plan* sends a notice to you, it will be sent to your last address on file with the *Group Insurance Commission*. For this reason, it is important for *Members* to keep their address current with the *GIC*.

Notice to *Tufts Health Plan*: *Members* should address all correspondence to:

Tufts Health Plan
Navigator Plan
705 Mt. Auburn Street
P.O. Box 9173
Watertown, MA 02471-9173

No Third Party Rights

The *Plan* grants rights to *Members*. It is not deemed to create rights in any third parties.

When this *Member Handbook* is Issued and Effective

This *Member Handbook* is issued and effective July 1, 2008 and supersedes all previous *Member Handbooks*.

Circumstances beyond *Tufts HP's* reasonable control

Tufts Health Plan shall not be responsible for a failure or delay in arranging for the provision of services in cases of circumstances beyond the reasonable control of *Tufts HP*. Such circumstances include, but are not limited to: major disaster; epidemic; war; riot; and civil insurrection. In such circumstances, *Tufts HP* will make a good faith effort to arrange for the provision of services.

Terms and Definitions

This section defines the terms used in this *Member Handbook*.

Adoptive Child

A *Child* under age 19 is an Adoptive *Child* as of the date he or she:

- is legally adopted by the *Subscriber*; or
- is placed for adoption with the *Subscriber*. This means that the *Subscriber* has assumed a legal obligation for the total or partial support of a *Child* in anticipation of adoption. If the legal obligation ceases, the *Child* is no longer considered placed for adoption.

Adult Medical and Surgical Services

Services which include the *Inpatient* care and treatment of *Members* age 18 and older for a medical or surgical condition (e.g., gynecological, gastroenterological, cardiological, and orthopedic services). Please note that *Inpatient* obstetric, pregnancy, and maternity care services are excluded from this definition. For more information about those services, see the "*Obstetric Services*" definition on page 80.

Annual Enrollment Period

The period each year when the *Group Insurance Commission* allows eligible persons to apply for and change coverage under Navigator and any other health plans the *GIC* offers.

Authorized Reviewer

Authorized Reviewers review and approve certain services and supplies to *Members*. Authorized Reviewers are:

- *Tufts Health Plan's Chief Medical Officer* (or equivalent); or
- someone he or she designates.

Calendar Year

The 12-month period beginning on January 1st and ending on December 31st. This 12-month period is when benefit limits, *Deductibles, Out-of-Pocket Maximums,* and *Coinsurance* are calculated.

Child (Children)

The *Subscriber's*:

- Child by birth, stepchild, or *Adoptive Child* who is under age 19; or
- *Adoptive Child;* or
- any other Child under age 19 for whom the *Subscriber* or *Spouse* has legal guardianship.

Coinsurance

The percentage of costs you must pay for certain *Covered Services*.

- For services provided by a non-*Tufts HP Provider*, your share is a percentage of the *Reasonable Charge* for those services.
- For services provided by a *Tufts HP Provider*, your share is the lesser of:
  - a percentage of the applicable *Tufts Health Plan* fee schedule amount for those services; or
  - a percentage of the *Tufts HP Provider's* actual charges for those services.

Contract Year

The 12-month period designated by the *Group Insurance Commission* and sometimes referred to as a plan year. (The plan year runs from July 1st through June 30th.)

Copayment

Fees you pay for certain *Covered Services* provided or authorized by a *Tufts HP Provider*. *Copayments* are paid to the *Provider* when you receive care unless the *Provider* arranges otherwise. *Copayments* are not applied towards any *Deductible*, *Coinsurance*, or *Out-of-Pocket Maximum*.

Copayment Tier 1 Specialist

A Massachusetts *Tufts HP Provider* who is a specialist and is rated as **excellent** (★★★) based on quality and cost-efficiency standards in one of the following 12 specialties: cardiology; dermatology; endocrinology; gastroenterology; general surgery; neurology; obstetrics/gynecology; ophthalmology; orthopedics; otolaryngology; rheumatology; and urology.

Copayment Tier 2 Specialist

A Massachusetts *Tufts HP Provider* who is a specialist and is rated as **good** (★★) based on quality and cost-efficiency standards in one of the following 12 specialties: cardiology; dermatology; endocrinology; gastroenterology; general surgery; neurology; obstetrics/gynecology; ophthalmology; orthopedics; otolaryngology; rheumatology; and urology.

Copayment Tier 3 Specialist

A Massachusetts *Tufts HP Provider* who is a specialist and is rated as **standard** (★) based on quality and cost-efficiency standards in one of the following 12 specialties: cardiology; dermatology; endocrinology; gastroenterology; general surgery; neurology; obstetrics/gynecology; ophthalmology; orthopedics; otolaryngology; rheumatology; and urology.

Cosmetic Services

Services performed solely for the purposes of improving appearance, which appearance is not the result of accidental injury, congenital anomaly or a previous surgical procedure or disease.

Covered Services

The services and supplies for which the *Plan* will pay. They must be:

- described in Part 5 of this *Member Handbook* (see pages 39-63);
- *Medically Necessary*, as determined by *Tufts Health Plan*; and
- in some cases, approved by an *Authorized Reviewer*.

Note: *Covered Services* include any surcharges on the plan such as the Massachusetts Uncompensated Care Pool or New York Health Care Reform Act surcharges, or later billed charges under provider network agreements, such as supplemental provider payments or access fee arrangements.

Custodial Care

- care provided primarily to assist in the activities of daily living, such as bathing, dressing, eating, and maintaining personal hygiene and safety;
- care provided primarily for maintaining the *Member's* or anyone else's safety, when no other aspects of treatment require an acute hospital level of care;
- services that could be provided by people without professional skills or training;
- routine maintenance of colostomies, ileostomies, and urinary catheters; or
- adult and pediatric day care.

Note: Custodial Care is not covered by the *Plan*.

Day Surgery

Any surgical procedure(s) in an operating room under anesthesia for which the *Member* is admitted to a facility licensed by the state to perform surgery, and with an expected discharge the same day. For hospital census purposes, the *Member* is an *Outpatient*, and not an *Inpatient*.

Deductible

The amount you pay in each *calendar year* for *Covered Services* at the *Out-of-Network level of benefits* before any payments are made under this *Member Handbook*.

Note: The amount credited towards the *Member's Deductible* is based on the *Tufts HP Provider* negotiated rate at the time the services are rendered and does not reflect any later adjustments, payments, or rebates.

Dependent

The *Subscriber's Spouse*, former *Spouse*, *Child*, *Student Dependent* or *Handicapped Child*, or *Child* of Dependent.

Directory of Health Care Providers

A separate booklet which lists:

- *Tufts HP Provider* physicians and their affiliated *Tufts HP Hospital*;
- hospitals in the *Tufts Health Plan* network (*Tufts HP Hospitals*); and
- certain other *Tufts HP Providers*.

Note: This booklet is updated from time to time to show changes in *Providers* affiliated with *Tufts Health Plan*. For information about the *Providers* listed in the *Directory of Health Care Providers*, please call Member Services or check the web site at **www.tuftshealthplan.com/gic**.

Durable Medical Equipment

Devices or instruments of a durable nature that:

- are *Medically Necessary*;
- are prescribed by a physician;
- are reasonable and necessary to sustain a minimum threshold of independent daily living;
- are made primarily to serve a medical purpose;
- are not useful in the absence of illness or injury;
- can withstand repeated use; and
- can be used in the home.

Effective Date

The date, according to *Tufts Health Plan's* records, when you become a *Member* and are first eligible for *Covered Services*.

Emergency

An illness or medical condition that manifests itself by symptoms of sufficient severity that the absence of prompt medical attention could reasonably be expected by a prudent lay person, who possesses an average knowledge of health and medicine, to result in:

- serious jeopardy to the physical and/or mental health of a *Member* or another person (or with respect to a pregnant *Member*, the *Member's* or her unborn child's physical and/or mental health); or
- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part; or
- with respect to a pregnant woman who is having contractions, inadequate time to effect a safe transfer to another hospital before delivery, or a threat to the safety of the *Member* or her unborn child in the event of transfer to another hospital before delivery.

Some examples of illnesses or medical conditions requiring *Emergency* care are severe pain, a broken leg, loss of consciousness, vomiting blood, chest pain, difficulty breathing, or any medical condition that is quickly getting much worse.

Experimental or Investigative

A service, supply, treatment, procedure, device, or medication (collectively "treatment") is considered Experimental or Investigative if any of the following apply:

- the drug or device cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished or to be furnished; or
- the treatment, or the "informed consent" form used with the treatment, was reviewed and approved by the treating facility's institutional review board or other body serving a similar function, or federal law requires such review or approval; or
- reliable evidence shows that the treatment is the subject of ongoing Phase I or Phase II clinical trials; is the research, experimental, study or investigative arm of ongoing Phase III clinical trials; or is otherwise under study to determine its safety, efficacy, toxicity, maximum tolerated dose, or its efficacy as compared with a standard means of treatment or diagnosis; or
- reliable evidence shows that more studies or clinical trials are necessary to determine the treatment's safety, efficacy, and positive effects on health outcomes.

Important Note: Reliable evidence showing more studies or clinical trials are necessary is based on the following two sources:

- Hayes Report ratings: Hayes is an independent health technology assessment organization. Hayes Technology Reports are independent, evidence-based analyses of the safety, efficacy, and cost-effectiveness of emerging health technologies. Hayes reports are developed by a team of medical research analysts, information specialists, reviewers, and editors. A treatment with a Hayes C or Hayes D rating is considered experimental or investigative.
- Peer reviewed published literature that is predominately non-randomized, historically controlled trials, case control or cohort studies with a high risk of confounding or bias, case reports or series, and/or expert opinion all indicate that more studies or clinical trials are necessary to determine the treatment's safety, efficacy, and positive effects on health outcomes.

Family Plan

Coverage for a *Subscriber* and his or her *Dependents*.

GIC

See *Group Insurance Commission*.

Group Insurance Commission

The Massachusetts state agency that provides health insurance for state and *Participating Municipality* employees, retirees, and their *Dependents.* Also referred to as "GIC."

Handicapped Child

The *Subscriber's Child* who:

- became permanently, physically or mentally Disabled before age 19;
- is incapable of supporting himself or herself due to disability; and
- was covered under the *Subscriber's Family Plan* immediately before reaching age 19 and who receives approval from the *GIC* to continue coverage under the *Family Plan*.

Individual Contract

An agreement between *Tufts Health Plan* and the *Subscriber* under which:

- *Tufts HP* agrees to provide *individual* coverage; and
- the *Subscriber* agrees to pay a premium to *Tufts HP*.

Individual Plan

Coverage for a *Subscriber* only (no *Dependents*).

Inpatient

A patient who is:

- admitted to a hospital or other facility licensed to provide continuous care; and
- classified as an Inpatient for all or a part of the day on the facility's Inpatient census.

Inpatient Copayment Tier 1

The *Copayment* you are responsible for paying for an *Inpatient* admission for *Obstetric Services, Pediatric Services,* or *Adult Medical and Surgical Services* in a *Tufts HP* Hospital that has received an **excellent** quality and efficiency rating.

Inpatient Copayment Tier 2

The *Copayment* you are responsible for paying for an *Inpatient* admission for *Obstetric Services, Pediatric Services,* or *Adult Medical and Surgical Services* in a *Tufts HP* Hospital that has received a **good** quality and efficiency rating.

In-Network Level of Benefits

The level of benefits that a *Member* receives for any *Covered Services* when care is provided by a *Tufts HP Provider*.

Medically Necessary

A service or supply that is consistent with generally accepted principles of professional medical practice as determined by whether that service or supply:

- is the most appropriate available supply or level of service for the *Member* in question considering potential benefits and harms to that individual;
- is known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes; or
- for services and interventions not in widespread use, as based on scientific evidence.

In determining coverage for *Medically Necessary* Services, *Tufts HP* uses *Medical Necessity* coverage guidelines which are:

- developed with input from practicing physicians in the *Tufts HP Service Area*;
- developed in accordance with the standards adopted by national accreditation organizations;
- updated at least biennially or more often as new treatments, applications and technologies are adopted as generally accepted professional medical practice; and
- evidence-based, if practicable.

Medical Supplies and Equipment

Items prescribed by a physician and which are *Medically Necessary* to treat disease and injury.

Member

A person enrolled in the Navigator Plan. Also referred to as "you."

Member Handbook

This document, including any future amendments, which describe the Navigator Plan.

Nongroup Coverage

A separate plan of coverage that may be available to a former *Member*.

Obstetric Services

The *Inpatient* care and treatment for any pregnancy-related condition once a diagnosis of pregnancy has been confirmed. Examples include childbirth (including newborn care while the mother and newborn *Child* are in the hospital), preterm labor, and the treatment of preeclampsia and eclampsia.

Outpatient

A patient who receives care other than on an *Inpatient* basis. This includes services provided in:

- a physician's office;
- a *Day Surgery* or ambulatory care unit; and
- an *Emergency* room or outpatient clinic.

Note: You are also an Outpatient when you are in a facility for observation.

Out-of-Network Level of Benefits

The level of benefits that a *Member* receives for *Covered Services* when care is not provided by a *Tufts HP Provider*.

Out-of-Pocket Maximum

The Out-of-Pocket Maximum is the maximum amount of money paid by a *Member* during a *calendar year* for *Covered Services* at the *Out-of-Network Level of Benefits.*

An Out-of-Pocket Maximum:

- consists of the *Deductible* and *Coinsurance*; and
- does not include any *Copayments*, Preregistration Penalties, costs for health care services that are not *Covered Services,* or services or supplies listed in the "Note" for the "*Out-of-Pocket Maximum"* provision on page 25.

Participating Municipality

A city, town or district of the Commonwealth of Massachusetts that participates in the health coverage offered by the *Group Insurance Commission*.

Pediatric Services

The *Inpatient* care and treatment of *Members* under age 18 for a medical or surgical condition. Please note that *Inpatient* obstetric, pregnancy, and maternity care services are excluded from this definition. For more information about those services, see the "Obstetric Services" definition on page 80.

Plan

Navigator by Tufts Health Plan™, the *Group Insurance Commission's* self-funded plan administered by *Tufts Health Plan*, which provides you with the benefits described in this *Member Handbook*.

Primary Care Physician

A *Tufts HP Provider* who is a general practitioner, family practitioner, internist or pediatrician who provides primary care services.

Prosthetic Devices

Medically Necessary items prescribed by a physician that replace all or part of a bodily organ or limb. Examples include breast prostheses and artificial limbs.

Provider

A health care professional or facility licensed in accordance with applicable law including, but not limited to, hospitals, limited service medical clinics, physicians, certified nurse midwives, certified registered nurse anesthetists, nurse practitioners, optometrists, podiatrists, licensed speech-language pathologists, and licensed audiologists.

The Navigator Plan will only cover services of a Provider, if those services are:

- listed as *Covered Services* in Part 5 of this *Member Handbook* (see pages 39-63); and
- within the scope of the Provider's license.

Provider Unit

A Provider Unit is comprised of doctors and other health care *Providers* who practice together in the same community and who often admit patients to the same hospital in order to provide their patients with a full range of care.

Reasonable Charge

The lesser of the

- amount charged; or
- amount that *Tufts Health Plan* determines, based upon nationally accepted means of claims payment and the fees most often charged by similar *Providers* for the same service in the geographic area in which it is given, to be the reasonable amount for the service. Nationally accepted means of claims payment includes, but is not limited to: CMS medical coding policies, AMA CPT coding guidelines, nationally recognized academy and society coding and clinical guidelines.

Routine Nursery Care

Routine care given to a well newborn *Child* immediately following birth until discharge from the hospital.

Service Area

The geographical area approved by the Massachusetts Commissioner of Insurance within which *Tufts Health Plan* has developed a network of *Providers* to afford *Members* with adequate access to *Covered Services*.

Spouse

The *Subscriber's* legal spouse, according to the law of the state in which you reside.

Student Dependent

The *Subscriber's Child* who is:

- enrolled as a full-time student at an accredited educational institution; and
- at least age 19 but less than age 26. Under certain conditions, *Student Dependents* may continue under the *Subscriber's* coverage at age 26 by paying an additional full cost individual premium (see page 36 for more information).

Subscriber

The person who:

- is an employee, a non-Medicare eligible retired employee, or non-Medicare eligible surviving spouse of an employee or retiree of the Commonwealth of Massachusetts or a *Participating Municipality;*
- enrolls in Navigator and signs the membership application form on behalf of himself or herself and any *Dependents*; and
- in whose name the premium contribution is paid.

Terms and Definitions, Continued

Tufts Health Plan or Tufts HP

Tufts Benefit Administrators, Inc., a Massachusetts Corporation d/b/a Tufts Health Plan. Tufts Health Plan enters into arrangements with groups or payors underwriting health benefit plans to make available a network of *Providers* and to provide certain administrative services to the health benefit plans including, but not limited to, processing claims for benefits and performing preregistration. *Tufts HP* does not insure the Navigator Plan.

Tufts HP Hospital

A hospital which has an agreement with *Tufts Health Plan* to provide certain *Covered Services* to *Members*. Tufts HP Hospitals are independent. They are not owned by *Tufts Health Plan*. Tufts HP Hospitals are not *Tufts Health Plan's* agents or representatives, and their staffs are not *Tufts Health Plan's* employees.

Tufts HP Provider

A *Provider* with whom *Tufts Health Plan* has an agreement to provide *Covered Services* to *Members*. *Providers* are not *Tufts Health Plan's* employees, agents or representatives.

Urgent Care

Care provided when your health is not in serious danger, but you need immediate medical attention for an unforeseen illness or injury. Examples of illnesses or injuries in which urgent care might be needed are a broken or dislocated toe, a cut that needs stitches but is not actively bleeding, sudden extreme anxiety, or symptoms of a urinary tract infection.

Part 10 – Non-Covered Drugs With Suggested Alternatives

This list of non-covered drugs is effective January 1, 2008 and may change during the year. Drugs may be added to this list for safety reasons, when a new drug comes to market, if a prescription drug becomes available over-the-counter, or if a generic version of a drug becomes available.

IMPORTANT NOTE: Please see the *Tufts Health Plan* Web site at **www.tuftshealthplan.com** for the most current list or call a Member Services Coordinator at 1-800-462-0224.

Brand Name	Suggested Alternatives and Additional Information
Abillify Discmelt	Ability tablets
Abilify Solution	Abilify tablets
Accupril	quinapril
Accuretic	quinapril/hydrochlorothiazide
AcipHex	Prilosec OTC (OTC, not covered), omeprazole, Nexium, or Prevacid
Alcet	oxycodone/acetaminophen
Alodox kit	doxycycline
Altoprev	lovastatin tablets
Ambien	zolpidem tartrate
Ambien CR	zolpidem tartrate
Amrix	cyclobenzaprine
Appbutamone	bupropion
Appbutamone-D	bupropion
Appformin	metformin
Appformin-D	metformin
Aquoral	saliva substitute (OTC, not covered), Salagen
Atacand	Benicar, Cozaar, or Diovan
Atacand HCT	Benicar HCT, Diovan HCT, or Hyzaar
Auralgan	A/B Otic, Benzotic, Aurodex
Avalide	Benicar HCT, Diovan HCT, or Hyzaar
Avapro	Benicar, Cozaar, or Diovan
Axid capsules	cimetidine, famotidine, nizatidine, or ranitidine
Beconase AQ	fluticasone nasal spray, flunisolide nasal spray
Benziq	benzoyl peroxide
Benziq LS	benzoyl peroxide
Binora	benzoyl peroxide
Bionect	Kerodex (OTC, not covered)
Brevoxyl-4 kit	benzoyl peroxide creamy wash
Brevoxyl-8 kit	benzoyl peroxide creamy wash
Caphosol	saliva substitute (OTC, not covered)
Capoten	captopril
Capozide	captopril/hydrochlorothiazide
Centany	mupirocin ointment, Bactroban cream
Clarinex	loratidine (OTC, not covered), fexofenadine
Clarinex-D 12-Hour	fexofenadine plus pseudoephedrine (pseudoephedrine is OTC, not covered)
Clarinex-D 24-Hour	loratidine plus pseudoephedrine (both are OTC, not covered), fexofenadine plus pseudoephedrine (pseudoephedrine is OTC, not covered)

Non-Covered Drugs With Suggested Alternatives, continued

Brand Name	Suggested Alternatives and Additional Information
Cleeravue-M	minocycline
ClindaReach	clindamycin phosphate 1%
Clobex spray	clobetasol
Combunox	oxycodone/ibuprofen
Coreg CR	carvedilol
Desonate	desonide cream/lotion
Durabac Forte	Mobigesic (OTC, not covered), acetaminophen (OTC, not covered)
Dynacin	minocycline capsules
EC Naprosyn	enteric-coated naproxen
Efudex (5% occlusion pack/kit)	fluorouracil cream
Eletone	Eucerin (OTC, not covered), Moisturin (OTC, not covered)
Emsam	Selegiline tablets
Extina	Ketoconazole cream or shampoo
Exubera	Humalog vial or Novolog vial
Factive	ciprofloxacin, ofloxacin, or Levaquin
Fentora	fentanyl citrate lollipop, Actiq
Fexmid	cyclobenzaprine
Flagyl, Flagyl ER	metronidazole tablets
Fortamet	metformin extended-release
Freshkote	Puralube Tears (OTC, not covered)
Gabazolamine	alprazolam
Gabitidine	ranitidine
Gaboxetine	fluoxetine
Genotropin	Norditropin, Norditropin Nordiflex
Glumetza	metformin ER
Glycolax	Miralax (OTC, not covered)
Humatrope	Norditropin, Norditropin Nordiflex
Hydro 40	urea lotion, urea cream
Hylira	Eucerin cream (OTC, not covered)
Hypertensolol	metoprolol
Inova	benzoyl peroxide wash, Stridex (OTC, not covered)
Inova 4/1, 8/2	benzoyl peroxide wash, Stridex (OTC, not covered)
Invega	Risperdal, Seroquel, Zyprexa
Iplex	increlex
itraconazole capsules	terbinafine tablets
Kerafoam	urea lotion, urea cream
Keralac Nailstik	urea nail gel, Keralac nail gel
Keralyt	Keralyt (OTC, not covered)
Kerol Redi-Cloths	urea cream, urea lotion
Kerol Topical Suspension	urea cream, urea lotion
Ketotifen Fumarate Ophthalmic Drops	Zaditor (OTC, not covered)
Klonopin	clonazepam

Non-Covered Drugs With Suggested Alternatives, continued

Brand Name	Suggested Alternatives and Additional Information
Klonopin wafers	clonazepam
Lagesic	Aceta-Gesic (OTC, not covered), Hyflex-DS
Lavoclen-4 kit	Lavoclen-4 topical liquid
Lavoclen-8 kit	Lavoclen-8 topical liquid
Lialda	Asacol, Pentasa
Lidosite	lidocaine-prilocaine cream
Lipofen	fenofibrate, Tricor
Liquicet	hydrocodone bitartrate/APAP, Hycet oral solution
Lopressor	metoprolol
Lotensin	benazepril
Lotensin HCT	benazepril/hydrochlorothiazide
Lovaza	omega-3 fish oil (OTC, not covered)
Lupron 1mg/ 0.2mL vial and kit	leuprolide 1mg/0.2 mL vial and kit
Lynox	oxycodone/acetaminophen tablets
Lytensopril	lisinopril tablets
Magnacet	oxycodone with acetaminophen tablets
Mavik	trandolapril
Megace ES	megestrol acetate oral suspension
Metrogel Combo Pak	metronidazole topical gel 0.75%, Metrogel 1%
Metronidazole 375 mg	metronidazole tablets
Mevacor	lovastatin
Micardis	Benicar, Diovan or Cozaar
Micardis HCT	Benicar HCT, Diovan HCT or Hyzaar
Minocin	minocycline capsules
Miralax	Miralax (OTC, not covered)
Mobic oral suspension	Meloxicam
Monodox	doxycycline monohydrate
Monopril	fosinopril
Monopril-HCT	fosinopril/hydrochlorothiazide
Mucotrol	Gelclair
Myrac	minocycline tablets
Namenda oral solution	Namenda tablets
Naprelan	naproxen sodium extended release
Neobenz Micro	benzoyl peroxide
Neobenz Micro SD	benzoyl peroxide
Niravam	alprazolam
Noxafil	fluconazole
Numoisyn	saliva substitute (OTC, not covered), Salivart

Non-Covered Drugs With Suggested Alternatives, continued

Brand Name	Suggested Alternatives and Additional Information
Nutropin	Norditropin, Norditropin Nordiflex
Nutropin AQ	Norditropin, Norditropin Nordiflex
Olux-E	Olux foam, clobetasole propionate emollient cream
Omnitrope	Norditropin, Norditropin Nordiflex
Opana	hydromorphone tablets, oxycodone tablets
Opana ER	oxycodone ER
Oracea	doxycycline
Orapred ODT	prednisolone sodium phosphate solution
Otosporin	Star-Otic (OTC, not covered)
Pataday	Zaditor (OTC, not covered), Patanol
Pepcid (except suspension)	cimetidine, famotidine, or ranitidine tablets
Peranex HC	Lidocaine-hydrocortisone-aloe kit
Perloxx	oxycodone/acetaminophen
polyethylene glycol 3350 oral powder	Miralax (OTC, not covered)
Pravachol	pravastatin
Prazolamine	carisoprodol tablets
Prevacid Naprapac	naproxen plus Prilosec OTC (Prilosec OTC is OTC, not covered); omeprazole; Nexium or Prevacid -
Prilosec	Prilosec OTC (OTC, not covered); omeprazole; Nexium or Prevacid **Please note**: Prilosec is covered for Members age 12 years and under
Prinivil	lisinopril
Prinzide	lisinopril/hydrochlorothiazide
Proquin XR	Ciprofloxacin
Prosed/DS	Uretron D/S, Urin D.S.
Pulmicort Flexhaler	Asmanex, Flovent HFA
Pulmophylline	theophylline
Pylera	PrevPac, Helidac
Rectagel HC	lidocaine-HC cream
Relamine	glucosamine/chondroitin (OTC, not covered)
Reprexain	hydrocodone/ibuprofen
Rimantalist	rimantadine
Rinnovi Nail System	urea cream, urea nail gel
Rosac wash	Clenia cleanser, Avar cleanser
Rosula cleanser	Prascion, Sulfatol

Non-Covered Drugs With Suggested Alternatives, continued

Brand Name	Suggested Alternatives and Additional Information
Rosula wash	Clenia cleanser, Avar cleanser
Senophylline	theophylline tablets
Sentradine	ranitidine
Sentroxatine	fluoxetine
Servira	Donnatal Extentabs
Solodyn	minocycline tablets
Soma 250 mg	carisoprodol tablets
Sporanox capsules	terbinafine tablets (Prior Authorization is required)
Staflex	Aceta-Gesic (OTC, not covered), Hyflex-DS
Strazepam	temazepam capsules
Taclonex	betamethasone dipropionate/calcipotriene ointment
Tandem F	Tandem (OTC, not covered) plus folic acid
Tekturna	Lisinopril, enalapril, Benicar, Cozaar, or Diovan
Tersi Foam	selenium sulfide shampoo
Teveten	Benicar, Cozaar, or Diovan
Teveten HCT	Benicar HCT, Diovan HCT, or Hyzaar
Tev-Tropin	Norditropin, Norditropin Nordiflex
Therabenzaprine	cyclobenzaprine
Theracodophen/ Theracodophen-Low	hydrocodone/acetaminophen
Therafeldamine	piroxicam
Therapentin	gabapentin
Theraproxen	ibuprofen
Theraproxen	naproxen sodium tablets
Theratramadol	tramadol
Trazamine	trazodone tablets
Tretin-X	tretinoin cream/gel
Triple Dye	Triple Dye Liquid (OTC, not covered)
Ultralytic 2	ammonium lactate
Ultram ER	tramadol
Umecta PD Topical Emulsion, Adhesive 40%	urea lotion, Umecta Topical Suspension
Umecta PD Topical Suspension, Adhesive 40%	urea lotion, Umecta Topical Suspension
Uniretic	moexipril/hydrochlorothiazide
Univasc	moexpril
urea nail stick 50%	urea nail gel 50%
Valium	diazepam
Vaseretic	enalapril/hydrochlorothiazide
Vasotec	enalapril
Veramyst	fluticasone propionate nasal spray
Verdeso	desonide cream/lotion

Non-Covered Drugs With Suggested Alternatives, continued

Brand Name	Suggested Alternatives and Additional Information
Vicoprofen	hydrocodone/ibuprofen
VSL#3 DS	VSL#3 (OTC, not covered)
Vusion	miconazole nitrate and zinc oxide (OTC, not covered)
Vyvanse	Concerta, Adderall XR
Xanax	alprazolam
Xanax XR	alprazolam extended-release
Xclair	Xenaderm ointment
Xolegel	ketoconazole cream
Xolegel Duo	ketoconazole cream plus Dandruff Shampoo (Dandruff Shampoo is OTC, not covered)
Xyralid	lidocaine-HC cream
Xyralid LP	lidocaine-HC lotion
Xyralid RC	Lidocaine-HC rectal
Zaditor	Zaditor OTC
Zegerid	Prilosec OTC (OTC, not covered); omeprazole; Nexium or Prevacid
Zelapar	selegiline tablets
Zestoretic	lisinopril/hydrochlorothiazide
Zestril	lisinopril
Ziana	tretinoin gel and clindamycin gel
Zinotic	Pramotic, Zolene HC
Zocor	simvastatin
Zoderm redi-pads	benzoyl peroxide
Zyflo CR	Singulair, Accolate
Zytopic	triamcinolone acetonide cream or ointment

Part 11 – Navigator Plan *Inpatient* Hospital *Copayment* Levels

Under the Navigator Plan, *Copayments* for *Inpatient* hospital stays at *Tufts HP Hospitals* for *Obstetric Services, Pediatric Services,* and *Adult Medical and Surgical Services* are grouped into two *Inpatient* Hospital *Copayment Tiers*, which are based upon the **quality and cost-efficiency rating** for each of these services. (You can call Member Services for more information about hospital groupings.)

- *Tufts HP Hospitals* with **an excellent quality and cost-efficiency rating** are grouped in ***Inpatient Copayment Tier 1***. *Inpatient Obstetric Services, Pediatric Services,* and *Adult Medical and Surgical Services* at a *Tufts HP Hospital* included in *Inpatient Copayment Tier 1* are subject to a **$200 *Copayment*** per admission*****.
- *Tufts HP Hospitals* with **a good quality and cost-efficiency rating** are grouped in ***Inpatient Copayment Tier 2***. *Inpatient Obstetric Services, Pediatric Services,* and *Adult Medical and Surgical Services* at a *Tufts HP Hospital* included in *Inpatient Copayment Tier* 2 are subject to a **$400 *Copayment*** per admission*.

*Subject to the *Inpatient* Care *Copayment* Maximum listed in the "*Inpatient* Care *Copayment* Maximum" provision on page 23 of this Navigator *Member Handbook.*

Important Note:

These *Copayment* Levels do not apply to:

- specialized hospitals (including the Massachusetts Eye and Ear Infirmary, the New England Baptist Hospital, or the Dana Farber Cancer Institute);
- *Tufts HP Hospitals* with fewer than 100 admissions per year for *Obstetric Services* and *Pediatric Services*; or
- *Tufts HP Hospitals* located outside of Massachusetts.

Your *In-Network* care at these *Tufts HP Hospitals* is subject to a $400 *Copayment* per admission for *Obstetric Services*, *Adult Medical and Surgical Services, and Pediatric Services* (subject to the *Inpatient* Care *Copayment* Maximum listed in the "*Inpatient* Care *Copayment* Maximum" provision on page 23 of this Navigator *Member Handbook.*

There are other *In-Network* services for which the *Inpatient* Hospital *Copayment* Tiers do not apply. These include:

- Services for newborn *Children* who stay in the hospital beyond the mother's discharge. **These services are covered in full.**
- Covered transplant services for *Members* at the *Plan's In-Network* Transplant Centers of Excellence. **These services are subject to a $200 *Copayment* per admission*.** Any additional *Inpatient* admission to an *In-Network Hospital* for *Covered Services* related to the transplant procedure(s) is subject to the applicable *Inpatient Hospital Copayment* in the "Navigator *Inpatient Hospital Copayment* List." Please see pages 90-93 of this Navigator *Member Handbook* for those *Copayment* amounts in effect as of July 1, 2008.
- Readmissions within 30 days of discharge in the same *calendar year*.

*****Subject to the *Inpatient* Care *Copayment* Maximum listed in the "*Inpatient* Care *Copayment* Maximum" provision on page 23 of this Navigator *Member Handbook.*

The Navigator *Inpatient* Hospital *Copayment* List, which appears in the following table, lists hospitals and the applicable *Copayments* for *Inpatient Obstetric Services*, *Pediatric Services*, or *Adult Medical and Surgical Services*.

Navigator *Inpatient* Hospital *Copayment* List

Eastern Massachusetts

Hospital Name	Obstetrical Care *Copayment*	Pediatric Care *Copayment*	Adult Medical/Surgical Care *Copayment*
Anna Jaques Hospital	$400	$400	**$200**
Beth Israel Deaconess Hospital – Needham	$400 (NL*)	$400 (NL*)	$400
Beth Israel Deaconess Medical Center	$400	$400 (NL*)	**$200**
Boston Medical Center	$400	**$200**	$400
Brigham and Women's Hospital	**$200**	$400 (NL*)	$400
Brockton Hospital	**$200**	**$200**	**$200**
Cambridge Hospital (Part of Cambridge Health Alliance)	**$200**	**$200**	$400
Cape Cod Hospital	**$200**	**$200**	**$200**
Caritas Carney Hospital	$400 (NL*)	$400	$400
Caritas Good Samaritan Medical Center	**$200**	$400 (NL*)	**$200**
Caritas Holy Family Hospital	$400	**$200**	$400
Caritas Norwood Hospital	$400	**$200**	$400
Caritas St. Elizabeth's Medical Center	$400	$400 (NL*)	$400
Caritas St. Anne's Hospital	$400 (NL*)	**$200**	**$200**
Children's Hospital	$400 (NL*)	$400	$400 (NL*)
Dana-Farber Cancer Institute	$400 (NL*)	$400 (NL*)	$400 (NL*)
Emerson Hospital	$400	$400	$400
Falmouth Hospital	$400	**$200**	**$200**
Faulkner Hospital	$400 (NL*)	$400 (NL*)	**$200**
Hallmark Health Systems (Lawrence Memorial or Melrose Wakefield Hospitals)	$400	$400 (NL*)	**$200**
Jordan Hospital	**$200**	**$200**	$400
Lahey Clinic Hospital	$400 (NL*)	$400 (NL*)	$400
Lawrence General Hospital	$400	**$200**	$400

NL* These hospitals are not grouped in a *Copayment* level because they: (1) are a specialized hospital, (2) have fewer than 100 admissions per year for pediatrics or obstetrics, (3) do not provide pediatric or obstetric services, or (4) are a network hospital outside of Massachusetts. Members are encouraged to contact their treating *Provider* or the hospital directly if they have questions about the services available at a specific *Hospital*.

Please note that the status and *Copayment* levels of our network of *Providers* listed above are in effect as of July 1, 2008. For the most up-to-date status, please contact Member Services at 1-800-870-9488.

Eastern Massachusetts, continued

Hospital Name	Obstetrical Care *Copayment*	Pediatric Care *Copayment*	Adult Medical/Surgical Care *Copayment*
Lowell General Hospital	**$200**	**$200**	**$200**
Massachusetts Eye and Ear Infirmary	$400 (NL*)	$400 (NL*)	$400 (NL*)
Massachusetts General Hospital	$400	$400	$400
Merrimack Valley Hospital	$400 (NL*)	$400 (NL*)	**$200**
Metrowest Medical Center - Framingham	$400	**$200**	**$200**
Metrowest Medical Center – Leonard Morse	$400	**$200**	**$200**
Milton Hospital	$400 (NL*)	$400 (NL*)	$400
Morton Hospital and Medical Center	$400	**$200**	**$200**
Mount Auburn Hospital	$400	$400 (NL*)	$400
New England Baptist Hospital	$400 (NL*)	$400 (NL*)	$400 (NL*)
Newton-Wellesley Hospital	**$200**	**$200**	**$200**
Northeast Health System (Addison Gilbert or Beverly Hospitals)	**$200**	**$200**	**$200**
North Shore Medical Center (Salem or Union Campuses)	$400	$400	$400
Quincy Medical Center	$400 (NL*)	$400 (NL*)	**$200**
Saints Memorial Medical Center	$400	$400 (NL*)	**$200**
South Shore Hospital	$400	$400	$400
Southcoast Health System (Charlton Memorial, St. Luke's, or Tobey Hospitals)	$400	$400 (NL*)	$400
Sturdy Memorial Hospital	$400	$400 (*NL)	$400
Tufts New England Medical Center	$400	**$200**	$400
Winchester Hospital	**$200**	**$200**	**$200**

NL* These *Hospitals* are not grouped in a *Copayment* level because they: (1) are a specialized hospital, (2) have fewer than 100 admissions per year for pediatrics or obstetrics, (3) do not provide pediatric or obstetric services, or (4) are a *Network Hospital* outside of Massachusetts. *Members* are encouraged to contact their treating *Provider* or the *Hospital* directly if they have questions about the services available at a specific *Hospital*.

Please note that the status and *Copayment* levels of our network of *Providers* listed above are in effect as of July 1, 2008. For the most up-to-date status, please contact Member Services at 1-800-870-9488.

Central Massachusetts

Hospital Name	Obstetrical Care *Copayment*	Pediatric Care *Copayment*	Adult Medical/Surgical Care *Copayment*
Athol Memorial Hospital	$400 (NL*)	$400 (NL*)	$400
Clinton Hospital	$400 (NL*)	$400 (NL*)	$400
Harrington Hospital	$400	$400	$400
HealthAlliance Hospitals	**$200**	**$200**	**$200**
Henry Heywood Hospital	$400	$400 (NL*)	**$200**
Hubbard Regional Hospital	$400 (NL*)	$400 (NL*)	$400
Marlborough Hospital	$400 (NL*)	$400 (NL*)	$400
Milford Regional Medical Center	$400	**$200**	**$200**
Nashoba Valley Medical Center	$400 (NL*)	$400 (NL*)	**$200**
St. Vincent Hospital	**$200**	$400	**$200**
UMass Memorial Medical Center	$400	$400	$400

Western Massachusetts

Hospital Name	Obstetrical Care *Copayment*	Pediatric Care *Copayment*	Adult Medical/Surgical Care *Copayment*
Baystate Medical Center	**$200**	**$200**	**$200**
Berkshire Medical Center	$400	**$200**	$400
Cooley Dickinson Hospital	**$200**	**$200**	$400
Fairview Hospital	$400	$400 (NL*)	$400
Franklin Medical Center	$400	$400 (NL*)	$400
Holyoke Hospital	$400	$400 (NL*)	**$200**
Mary Lane Hospital	$400	$400 (NL*)	**$200**
Mercy Medical Center	**$200**	$400 (NL*)	**$200**
Noble Hospital	$400 (NL*)	$400 (NL*)	**$200**
North Adams Regional Hospital	$400	$400 (NL*)	$400
Wing Memorial Hospital	$400 (NL*)	$400 (NL*)	**$200**

NL* These *Hospitals* are not grouped in a *Copayment* level because they: (1) are a specialized hospital, (2) have fewer than 100 admissions per year for pediatrics or obstetrics, (3) do not provide pediatric or obstetric services, or (4) are a *Network Hospital* outside of Massachusetts. *Members* are encouraged to contact their treating *Provider* or the *Hospital* directly if they have questions about the services available at a specific *Hospital*.

Please note that the status and *Copayment* levels of our network of *Providers* listed above are in effect as of July 1, 2008. For the most up-to-date status, please contact Member Services at 1-800-870-9488.

New Hampshire

Hospital Name	**Obstetrical Care *Copayment***	**Pediatric Care *Copayment***	**Adult Medical/Surgical Care *Copayment***
Catholic Medical Center	$400 (NL*)	$400 (NL*)	$400 (NL*)
Elliot Hospital	$400 (NL*)	$400 (NL*)	$400 (NL*)
Mary Hitchcock Memorial Medical Center	$400 (NL*)	$400 (NL*)	$400 (NL*)
Parkland Medical Center	$400 (NL*)	$400 (NL*)	$400 (NL*)
Southern N.H. Regional Medical Center	$400 (NL*)	$400 (NL*)	$400 (NL*)
St. Joseph Hospital	$400 (NL*)	$400 (NL*)	$400 (NL*)

Rhode Island

Hospital Name	**Obstetrical Care *Copayment***	**Pediatric Care *Copayment***	**Adult Medical/Surgical Care *Copayment***
Kent County Hospital	$400 (NL*)	$400 (NL*)	$400 (NL*)
Landmark Medical Center	$400 (NL*)	$400 (NL*)	$400 (NL*)
Memorial Hospital of RI	$400 (NL*)	$400 (NL*)	$400 (NL*)
Miriam Hospital	$400 (NL*)	$400 (NL*)	$400 (NL*)
Newport Hospital	$400 (NL*)	$400 (NL*)	$400 (NL*)
Rhode Island Hospital – including Hasbro Children's Hospital	$400 (NL*)	$400 (NL*)	$400 (NL*)
Roger Williams Medical Center	$400 (NL*)	$400 (NL*)	$400 (NL*)
St. Joseph's Hospital	$400 (NL*)	$400 (NL*)	$400 (NL*)
Women and Infants Hospital	$400 (NL*)	$400 (NL*)	$400 (NL*)

NL * These *Hospitals* are not grouped in a *Copayment* level because they: (1) are a specialized hospital, (2) have fewer than 100 admissions per year for pediatrics or obstetrics, (3) do not provide pediatric or obstetric services, or (4) are a *Network Hospital* outside of Massachusetts. *Members* are encouraged to contact their treating *Provider* or the *Hospital* directly if they have questions about the services available at a specific *Hospital*.

Please note that the status and *Copayment* levels of our network of *Providers* listed above are in effect as of July 1, 2008. For the most up-to-date status, please contact Member Services at 1-800-870-9488.

United Behavioral Health

Member Handbook

Mental Health, Substance Abuse, and Enrollee Assistance Programs

Description of Benefits

PART I -- HOW TO USE THIS PLAN

A COMPREHENSIVE PLAN DESIGNED WITH YOUR WELL-BEING IN MIND

As a covered person under Navigator, you are automatically enrolled in the mental health and substance abuse benefits program as well as the Enrollee Assistance Program (EAP) administered by United Behavioral Health. These programs offer you easy access to a broad range of services -- from assistance with day-to-day concerns (e.g., legal and financial consultations, workplace-related stress, child- and elder-care referrals) to more serious mental health and substance abuse needs, including assistance in a psychiatric emergency. By offering effective, goal-focused care delivered by a network of highly qualified providers, this program is designed to improve well-being and functioning as quickly as possible.

United Behavioral Health (UBH) administers the benefits under this program on behalf of the Group Insurance Commission (GIC). With a proven track record of providing EAP services and managing care for more than 43 million people, UBH can successfully meet the diverse needs of Navigator Plan covered persons.

UNITED BEHAVIORAL HEALTH WILL BE BRANDED AS OPTUMHEALTH BEHAVIORAL SOLUTIONS

Effective January 1, 2009, UBH will be operating under the brand name of OptumHealth Behavioral Solutions. This new brand name illustrates their continuing mission to optimize the health and well-being of GIC members.

Please note that this is only a brand name, and it will not affect any of their operations and procedures as described in this handbook. Their corporate entity is still registered as United Behavioral Health.

LET US SHOW YOU THE BENEFITS

The following describes your mental health, substance abuse and EAP benefits under the UBH/OptumHealth Behavioral Solutions plan. Please read it carefully before you seek care to ensure that you receive maximum benefits. The chart on pages 102-103 provides a brief overview of your benefits; however, it is not a detailed description. The detailed description of your benefits is found in Part III on pages 104-108. Words in italics throughout this description are defined in the "Definitions" section in Part II.

HOW TO ENSURE MAXIMUM BENEFITS

In order to receive maximum benefits and reduce your out-of-pocket expenses, there are two important steps you need to remember:

Step 1: Call UBH/OptumHealth Behavioral Solutions for *precertification* before you seek EAP, mental health, or substance abuse services; and

Step 2: Use a provider or facility from the UBH/OptumHealth Behavioral Solutions network.

UBH/OptumHealth Behavioral Solutions offers you a comprehensive network of resources and experienced providers from which to obtain EAP, mental health and substance abuse services. All UBH/OptumHealth Behavioral Solutions *network providers* have been reviewed by UBH/OptumHealth Behavioral Solutions for their ability to provide quality care. If you receive care from a provider or facility that is not part of the UBH/OptumHealth Behavioral Solutions network, your benefit level will be lower than the network level. These reduced benefits are defined as *out-of-network benefits*. If you fail to call UBH/OptumHealth Behavioral Solutions to *precertify* your care, you may be charged a penalty and your benefits may be reduced. In some cases if you fail to *precertify* your care, no benefits will be paid. Please refer to Part III, titled **Benefits Explained**, on pages 104-108, for a full description of your *network* and *out-of-network benefits,* as well as special *precertification* requirements for certain *out-of-network* outpatient services. **Benefits will be denied if your care is considered not to be a covered service.**

BEFORE YOU USE YOUR BENEFITS

PRECERTIFICATION

Precertification is the first step to obtaining your EAP, mental health and substance abuse benefits. To receive EAP services or before you begin mental health and substance abuse care, call UBH/OptumHealth Behavioral Solutions at 1-888-610-9039 (TDD: 1-800-842-9489).

A trained UBH/OptumHealth Behavioral Solutions clinician will answer your call 24 hours a day, seven days a week, verify your coverage and refer you to a specialized EAP resource or a *network provider*. All UBH/OptumHealth Behavioral Solutions clinicians are experienced professionals with master's degrees in psychology, social work, or a related field. A UBH/OptumHealth Behavioral Solutions clinician will immediately be available to assist you with routine matters or in an emergency. If you have specific questions about your benefits or claims, call a customer service representative from 9 a.m. to 8 p.m. Eastern Time at 1-888-610-9039 (TDD: 1-800-842-9489).*

Based on your specific needs, the UBH/OptumHealth Behavioral Solutions clinician will *precertify* visits if you are eligible for coverage at the time of your call, and provide you with the names of several mental health, substance abuse or EAP providers who match your request (e.g., provider location, gender, or fluency in a second language). UBH/OptumHealth Behavioral Solutions maintains an extensive database of information on every provider in the network. (A directory of UBH/OptumHealth Behavioral Solutions providers can be found on the UBH/OptumHealth Behavioral Solutions web site, liveandworkwell.com (access code 10910). After *precertification*, you can then call the provider directly to schedule an appointment. **If you need assistance, a UBH/OptumHealth Behavioral Solutions clinician can help you in scheduling an appointment.** The UBH/OptumHealth Behavioral Solutions clinician can also provide you with a referral for legal, financial, or dependent care assistance or community resources, depending on your specific needs.

EMERGENCY CARE

Emergency care is required when a person needs immediate clinical attention because he or she presents a real and significant risk to him/herself or others. In a life-threatening emergency, you and/or your covered dependents should seek care immediately at the closest emergency facility. You, a family member or your provider must call UBH/OptumHealth Behavioral Solutions **within 24 hours** of an emergency admission to notify UBH/OptumHealth Behavioral Solutions of the admission. Although a representative may call on your behalf, it is always the covered person's responsibility to ensure that UBH/OptumHealth Behavioral Solutions has been notified. If UBH/OptumHealth Behavioral Solutions is not notified of the admission, you will not be eligible for maximum benefits or benefits may be denied. UBH/OptumHealth Behavioral Solutions staff is available 24 hours a day to assist you and/or your covered family members.

URGENT CARE

There may be times when a condition shows potential for becoming an emergency if not treated immediately. In such urgent situations, our providers will have an appointment to see you within 24 hours of your initial call to UBH/OptumHealth Behavioral Solutions.

ROUTINE CARE

Routine care is for conditions that present no serious risk, and are not in danger of becoming an emergency. For routine care, *network providers* will have appointments to see you within three days of your initial call to UBH/OptumHealth Behavioral Solutions.

ENROLLEE ASSISTANCE PROGRAM

Your Enrollee Assistance Program benefit provides access to a range of resources, as well as focused, confidential, short-term counseling to treat problems of daily living (e.g., emotional, marital or family problems, legal disputes, or financial difficulties). The EAP benefit provides counseling and other professional services to you and your family members who are experiencing problems disrupting your personal and professional lives (e.g. international events, community trauma). The EAP can also provide critical incident response and on-site behavioral health consultation for State agencies and municipalities.

---

* As part of UBH's/OptumHealth Behavioral Solutions' quality control program, supervisors monitor random calls to UBH's/OptumHealth Behavioral Solutions' customer services department, but not the clinical department.

CONFIDENTIALITY

When you use your EAP, mental health and substance abuse benefits under this plan, you are consenting to the release of necessary clinical records to UBH/OptumHealth Behavioral Solutions for *case management* and benefit administration purposes. Information from your clinical records will be provided to UBH/OptumHealth Behavioral Solutions only to the minimum extent necessary to administer and manage the care provided when you use your EAP, mental health and substance abuse benefits, and in accordance with state and federal laws. All of your records, correspondence, claims, and conversations with UBH/OptumHealth Behavioral Solutions staff are kept **completely confidential** in accordance with federal and state laws. No information may be released to your supervisor, employer, or your family without your written permission, and no one will be notified when you use your EAP, mental health and substance abuse benefits. UBH/OptumHealth Behavioral Solutions staff must comply with a strict confidentiality policy.

COMPLAINTS

If you are not satisfied with any aspect of the UBH/OptumHealth Behavioral Solutions program, we encourage you to call UBH/OptumHealth Behavioral Solutions at 1-888-610-9039 (TDD: 1-800-842-9489) to speak with a customer service representative. The UBH/OptumHealth Behavioral Solutions member services representative resolves most inquiries during your initial call. Inquiries that require further research are reviewed by representatives of the appropriate departments at UBH/OptumHealth Behavioral Solutions, including clinicians, claims representatives, administrators, and other management staff who report directly to senior corporate officers. We will respond to all inquiries within three business days. Your comments will help us correct any problems and provide better service to you and your dependents. If the resolution of your inquiry is unsatisfactory to you, you have the right to file a formal *complaint* in writing within 60 days of the date of our telephone call or letter of response. Please specify dates of service and additional contact with UBH/OptumHealth Behavioral Solutions and include any information you feel is relevant. Formal *complaints* will be responded to in writing within 30 days. A formal *complaint* should be sent to:

United Behavioral Health
Complaint Unit
100 East Penn Square
Suite 400
Philadelphia, PA 19107

APPEALS

YOUR RIGHT TO AN INTERNAL APPEAL

You, your treating provider, or someone acting on your behalf have the right to request an *appeal* of the benefit decision made by UBH/OptumHealth Behavioral Solutions. You may request an *appeal* in writing by following the steps below.

If your care needs are urgent (meaning that a delay in making a treatment decision could significantly increase the risk to your health, could result in severe pain, or could impact your ability to regain maximum function), please see the section entitled “Expedited Internal Appeal Review Process” on page 98.

HOW TO INITIATE A FIRST LEVEL INTERNAL APPEAL (NON-URGENT APPEAL)

Your *appeal* request must be submitted to us within 180 days after the date you received notice of your benefit coverage determination. Written requests should be submitted to the following address:

United Behavioral Health
Appeals Department
100 East Penn Square
Suite 400
Philadelphia, PA 19111

1-800-842-1311 x 5718
Fax Number: 1-866-302-4472

Appeal requests must include:

- The patient's name and the identification number from the ID card.
- The date(s) of service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

THE FIRST LEVEL INTERNAL APPEAL REVIEW PROCESS (NON-URGENT APPEAL)

A board certified psychiatrist in the same or similar specialty area as your treating psychiatrist will review and make the decision about your *appeal* request. If your treating provider is not a psychiatrist, a doctoral-level psychologist or a psychiatrist who has not had any previous involvement in your *appeal* case will review and make a decision about your *appeal* request. The UBH/OptumHealth Behavioral Solutions psychiatrist or psychologist will not have had any previous involvement in decisions about your case. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits.

Prior to the *appeal* review, you and your provider have the opportunity to submit any additional information or documentation that you would like to be considered as part of the *appeal* review. Examples of such information are: records relating to the current conditions or treatment, co-existent conditions, or any other relevant information.

UBH/OptumHealth Behavioral Solutions will notify you, or your authorized representative and your provider, of the *appeal* resolution in writing within thirty (30) calendar days of UBH's/OptumHealth Behavioral Solutions' receipt of your *appeal* request. If this is an *appeal* for services you have not yet received, UBH/OptumHealth Behavioral Solutions will complete the review and notify you of the outcome within fifteen (15) calendar days of your request. The notification will include the specific information upon which the determination was based.

HOW TO INITIATE A SECOND LEVEL INTERNAL APPEAL (NON-URGENT APPEAL)

If you remain dissatisfied with the outcome of the first level *appeal* review, you may request a second level standard *appeal* review. A second level standard *appeal* must be requested within sixty (60) calendar days from the date on your first level *appeal* notification letter you received from UBH/OptumHealth Behavioral Solutions.

The UBH/OptumHealth Behavioral Solutions Appeal Reviewer conducting the review will not have been involved in a prior benefit determination for the treatment episode nor will the Appeal Reviewer be a subordinate of the UBH/OptumHealth Behavioral Solutions reviewer who made previous benefit determinations for the treatment episode. If your *appeal* is related to a clinical benefit coverage determination, the review will be done in consultation with a behavioral health care professional with appropriate expertise in the field, who was not involved in the prior benefit determination.

To request a second level standard *appeal*, contact UBH/OptumHealth Behavioral Solutions at the address listed above. Prior to the *appeal* review being conducted, you and your provider have the opportunity to submit any additional information or documentation that you would like considered as part of the second level *appeal* review. You may also request copies, free of charge, of any relevant documents, records, or other information UBH/OptumHealth Behavioral Solutions used to make its *appeal* decision.

As in the first level *appeal* review, UBH/OptumHealth Behavioral Solutions will notify you, or your authorized representative and your provider of the *appeal* resolution in writing within thirty (30) calendar days of receipt of your *appeal* request. If this is an *appeal* for services you have not yet received, UBH/OptumHealth Behavioral Solutions will complete the review and notify you of the outcome within fifteen (15) calendar days of your request.

EXPEDITED INTERNAL APPEAL REVIEW PROCESS

Your *appeal* may require immediate action if a delay in treatment could significantly increase the risk to your health, could result in severe pain, or could impact your ability to regain maximum function. In these urgent situations:

- The *appeal* does not need to be submitted in writing. You or your provider should call us as soon as possible using the phone number listed above.
- An expedited *appeal* will be reviewed, a decision made, and you and your provider notified within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.

THIRD LEVEL INTERNAL REVIEW PROCESS

If you remain dissatisfied with the outcome of the Second Level Appeal review, you may request a third level *appeal* to the Group Insurance Commission. The request must be made in writing to Group Insurance Commission within thirty (30) days of the receipt of the Second Level Appeal outcome letter.

To request a third level *appeal*, contact the Group Insurance Commission at the address listed below:

Appeals Unit
Group Insurance Commission
Commonwealth of Massachusetts
P.O.Box 8747
Boston, MA 02114-8747

Prior to the *appeal* review being conducted, you and your provider have the opportunity to submit any additional information or documentation that you would like considered as part of the appeals review. You may also request copies, free of charge, of any relevant documents, records, or other information UBH/OptumHealth Behavioral Solutions used to make its *appeal* decision.

The Group Insurance Commission will notify you, or your authorized representative and your provider of the *appeal* resolution in writing within thirty (30) calendar days of receipt of your *appeal* request.

FILING CLAIMS

Network providers and facilities will file your claim for you. You are financially responsible for *deductibles* and *copayments*.

Out-of-network providers are not required to process claims on your behalf; you must submit the claims yourself. You are responsible for all *coinsurance,* and *deductibles*. Send the *out-of-network provider's* itemized bill and a completed CMS 1500 claim form, with your name, address, and GIC ID number to:

United Behavioral Health
Claims
Post Office Box 30755
Salt Lake City, UT 84130-0755

The CMS 1500 form is available from your provider. Claims must be received by UBH/OptumHealth Behavioral Solutions within 15 months of the date of service for you or a covered dependent. You must be eligible for coverage on the date you received care. All claims are confidential.

COORDINATION OF BENEFITS

All benefits under this plan are subject to *coordination of benefits*, which determines whether your mental health and substance abuse care is partially or fully covered by another plan. UBH/OptumHealth Behavioral Solutions may request information from you about other health insurance coverage in order to process your claim correctly.

FOR MORE INFORMATION

UBH/OptumHealth Behavioral Solutions customer service staff is available to help you. Call 1-888-610-9039 (TDD: 1-800-842-9489) for assistance Monday through Friday, from 9 a.m. to 8 p.m. Eastern Time.

PART II -- BENEFIT HIGHLIGHTS

DEFINITIONS OF UBH/OPTUMHEALTH BEHAVIORAL SOLUTIONS TERMS

Allowed Charges means charges conform to UBH/OptumHealth Behavioral Solutions negotiated fee maximums or reasonable and customary rates. If the cost of treatment for out-of-network care exceeds the *allowed charges*, the covered person may be responsible for the difference.

Appeal means a formal request for UBH/OptumHealth Behavioral Solutions to reconsider any adverse determination/denial of coverage, either concurrently or retrospectively, for admissions, continued stays, levels of care, procedures, or services.

Case Management means a system of *continuing review* by a UBH/OptumHealth Behavioral Solutions clinical case manager, using objective clinical criteria, to determine if treatment is appropriate and a covered service according to the plan of benefits for a covered diagnostic condition.

Coinsurance means the limit of coverage by the plan to a certain percentage of provider costs and fees, such as 80%. The remaining percentage is paid by the covered person. The provider is responsible for billing the member for the remaining percentage.

Complaint means a verbal or written statement of dissatisfaction arising from a perceived adverse administrative action, decision, or policy by UBH/OptumHealth Behavioral Solutions.

Continuing Review/Concurrent Review means an assessment of the care while it is being delivered and the proposed treatment plan for future care, conducted at periodic intervals by a clinical case manager to determine the appropriateness of continued care.

Coordination of Benefits (COB) means a methodology which determines the order and proportion of insurance payment when a covered person has coverage through more than one insurer. The regulations define which organization has primary responsibility for payment and which organization has secondary responsibility for any remaining charges not covered by the “primary plan.”

Copayment means a fixed dollar amount that a covered person must pay out of his or her own pocket.

Covered Services are services and supplies provided for the purpose of preventing, diagnosing or treating a behavioral disorder, psychological injury or substance abuse addiction and which are described in the section titled "What This Plan Pays," and not excluded under the section titled "What’s Not Covered - Exclusions."

Cross Accumulation means the sum of applicable expenses paid by a covered person to determine whether a *deductible* or *out-of-pocket maximum* has been reached.

Deductible means the designated amount that a covered person must pay for any charges before insurance coverage applies.

Intermediate Care means care that is more intensive than traditional outpatient treatment but less intensive than 24-hour hospitalization. Some examples are residential treatment, group homes, halfway houses, therapeutic foster care, day or partial hospital programs, or structured outpatient programs.

Network Provider is a provider who participates in the UBH/OptumHealth Behavioral Solutions network.

Non-Notification Penalty means the amount charged when you fail to *precertify* care. It does not count towards the *out-of-pocket maximum.*

Out-of-Network Provider is a provider who does not participate in the UBH/OptumHealth Behavioral Solutions network.

Out-of-Pocket Maximum means the maximum amount you will pay in *coinsurance* and *copayments* for your mental health and substance abuse care in one calendar year. When you have met your *out-of-pocket maximum,* all care will be covered at 100% of the *allowed charge* until the end of that calendar year. This maximum does not include the *non-notification penalty*, charges for out-of-network care that exceed the maximum number of covered days or visits, out-of-network outpatient service costs, the out-of-network calendar year *deductible*, the out-of-network inpatient *deductible*, charges for care not deemed to be a covered service, and charges in excess of UBH's/OptumHealth Behavioral Solutions' *allowed charges*.

Precertification (Precertify) is the process of registering for services with UBH/OptumHealth Behavioral Solutions prior to seeking EAP, mental health and substance abuse care. All *precertification* is performed by *UBH/OptumHealth Behavioral Solutions clinicians*.

UBH/OptumHealth Behavioral Solutions Clinician refers to the staff member who *precertifies* EAP, mental health and substance abuse services. *UBH/OptumHealth Behavioral Solutions clinicians* must have the following qualifications: Master's degree in psychology, social work, or a related field; three or more years of clinical experience; Certified Employee Assistance Professionals (CEAP) certification or eligibility; and a comprehensive understanding of the full range of EAP services for employees and employers, including workplace and personal concerns.

WHAT THIS PLAN PAYS

The Plan pays for the following services:

- **Outpatient Care** - Individual or group sessions with a therapist, usually conducted once a week, in the provider's office or facility.
- **Intermediate Care** - Care that is more intensive than traditional outpatient services, but less intensive than 24-hour hospitalization. Some examples are residential treatment, group homes, halfway houses, day/partial hospitals, or structured outpatient programs.
- **In-Home Care** - A licensed mental health professional visits the patient in his or her home.
- **Inpatient Care** - Treatment in a hospital or substance abuse facility.
- **Detoxification** - Medically supervised withdrawal from an addictive chemical substance, which may be done in a substance abuse facility.
- **Drug Testing** - *Precertified* drug testing is covered as an adjunct to substance abuse treatment.

The Plan also covers:

- **Enrollee Assistance Program** - Short-term counseling or other services that focus on problems of daily living, such as marital problems, conflicts at work, legal or financial difficulties, and dependent care needs.
- **www.liveandworkwell.com** - An interactive web site offering a large collection of wellness articles, service databases including a UBH/OptumHealth Behavioral Solutions Massachusetts *network provider* directory, tools, financial calculators and expert chats. To enter the site, log on to www.liveandworkwell.com and enter access code 10910.

These services are subject to certain Exclusions, which are found in Part III.

Benefits Chart

The following chart summarizes certain benefits available to you. Be sure to read Part III which describes your benefits in detail and notes some important restrictions. Remember, in order to receive the maximum benefits, you must *precertify* your care with UBH/OptumHealth Behavioral Solutions before you begin treatment. For assistance, call 24 hours a day, seven days a week: 1-888-610-9039 (TDD: 1-800-842-9489).

Covered Services	Network Benefits	Out-of-Network Benefits
Annual *Deductible*	None	$150 per person (a,b) $300 per family (a,b)
Out-of-Pocket Maximum	$1,000 per individual (a) $2,000 per family	$3,000 per member (a) No family maximum
Benefit Maximums	Unlimited	Unlimited
Inpatient Care		
Deductible	$200 per calendar quarter (a,c)	$150 per admission (applies after annual *deductible* is met) (a)
Mental Health General Hospital Psychiatric Hospital	Full coverage	80% of *allowed charges*
Substance Abuse General Hospital or Substance Abuse facility	Full coverage	80% of *allowed charges*
	All hospital care must be *precertified*. Emergency admissions must be *precertified* within 24 hours to receive maximum benefits. *Non-notification penalty* for failure to *precertify* care is $200. *Non-notification penalty* does not count toward *out-of-pocket maximums*.	
Intermediate care (d)		
Care that is more intensive than traditional outpatient services, but less intensive than 24-hour hospitalization. Examples are residential treatment, group homes, halfway houses, day/partial hospitals, or structured outpatient programs	Full coverage	80% of *allowed charges* after *deductible* is met

Covered Services	Network Benefits	Out-of-Network Benefits
Outpatient Care (d, e, f, g)- Mental Health, Substance Abuse and Enrollee Assistance program (EAP)		
Enrollee Assistance Program (EAP)		
	Up to 3 visits: 100% Note: EAP *non-notification penalty* reduces benefit to zero: no benefits paid.	No Coverage for EAP
Mental Health and Substance Abuse		
Individual and family therapy	100%, after $15 per visit After $10 copay, full coverage	First 15 visits: 80% of *allowed charges* (e, f) Visits 16 and over: 50% of *allowed charges* (e, g)
Group therapy	100%, after $10 per visit	First 15 visits: 80% of *allowed charges* (e, f) Visits 16 and over: 50% of *allowed charges* (e, g)
Medication Management: (15 - 30 minute psychiatrist visit.)	100%, after $10 per visit	First 15 visits: 80% of *allowed charges* (e, f) Visits 16 and over: 50% of *allowed charges* (e, g)
In-Home Mental Health Care	Full coverage	First 15 visits: 80% of *allowed charges* (e, f) Visits 16 and over: 50% of *allowed charges* (e, g)
Drug Testing (as an adjunct to Substance Abuse treatment)	Full coverage *Non-notification penalty* reduces benefit to zero: no benefits paid.	No coverage
Provider Eligibility - Provider must be licensed in one of these disciplines.	MD Psychiatrist, PhD, PsyD, EdD, MSW, MSN, LICSW, RNMSCS, MA (h)	MD Psychiatrist, PhD, PsyD, EdD, MSW, MSN, LICSW, RNMSCS, MA (h)
Notes		
(a)	Separate from medical *deductible* and medical *out-of-pocket maximum*. *Network and out-of-network out-of-pocket maximums* do not *cross accumulate*.	
(b) (c)	*Cross accumulates* with all *Out-of-network* mental health and substance abuse benefit levels.	
(d)	Waived if readmitted within 30 days: maximum one *deductible* per calendar quarter.	
(e)	Treatment that is not *precertified* receives *Out-of-network* level of reimbursement, except as noted in item (g) below.	
(f)	All *Out-of-network* visits in a given calendar year are accumulated to determine the appropriate *out-of-network* level of reimbursement.	
(g)	No *precertification* is required for *out-of-network* outpatient visits 1 through 15 per calendar year.	
(h)	*Out-of-network* outpatient visits 16 and over, per calendar year, are subject to the same precertification requirement as *Network* benefits in order to be eligible for coverage. Massachusetts independently licensed providers: psychiatrists, psychologists, licensed clinical social workers, psychiatric nurse clinical specialists and allied mental health professionals. Please note: the words in italics have special meanings that are defined in the Glossary section.	

Part III – BENEFITS EXPLAINED

MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS

NETWORK SERVICES

In order to receive maximum network benefits for EAP, mental health and substance abuse treatment you must call UBH/OptumHealth Behavioral Solutions at 1-888-610-9039 (TDD: 1-800-842-9489) to *precertify* care and obtain a referral to a *network provider*.

Precertified network care has no *deductible*. *Covered services* are paid at 100% after the appropriate *copayments* (see *copayment* schedule below). The calendar year *out-of-pocket maximum* for network services is $1,000 per individual and $2,000 per family.

The following do not count toward the *out-of-pocket maximum*:

- *Non-notification penalties.*
- Cost of treatment subject to exclusions.

If you fail to *precertify* your care, you will be charged a *non-notification penalty*. The *non-notification penalty* for each type of service is listed in the Benefit Highlights chart on pages 102-103, and in the following descriptions of services.

NETWORK BENEFITS

Outpatient Care
The *copayment* schedule for *network* outpatient *covered services* is shown below:

Individual and family therapy, all visits -	$15 copayment
Medication Management, all visits -	$10 copayment
Group Therapy, all visits -	$10 copayment
Enrollee Assistance Program, Up to 3 visits-	No copayment

Failure to *precertify* outpatient care results in a benefit reduction to the *out-of-network* level reimbursement, and in some cases, may result in no coverage.

In-Home Care
In-home care is a covered service if *precertified*. Treatment that is *not pre-certified* but deemed to be a covered service receives out-of-network level reimbursement, and in some cases, may result in no coverage. Please refer to the section titled ***Out-of-network* Services** below for details.

Intermediate Care
Intermediate care is covered if *precertified*. This includes, but is not limited to, 24-hour *intermediate care* facilities (for example, residential treatment, group homes, halfway houses, day/partial hospital, and structured outpatient treatment programs). *Intermediate care* that is not pre-certified but deemed to be a covered service receives out-of-network level reimbursement.

Inpatient Care
Network inpatient care deemed to be a covered service in a general or psychiatric hospital, or substance abuse facility if *precertified* is covered at 100% after a $200 per calendar quarter *deductible*. The *deductible* is waived if readmitted within 30 days with a maximum of one *deductible* per calendar quarter. There is a $200 *non-notification penalty* for failure to *precertif*y inpatient care.

Drug Testing
Precertified drug testing is covered as an adjunct to substance abuse treatment.

Psychological Testing
Psychological testing, including neuropsychological testing, that is deemed to be a covered service is covered when *precertified*. Psychological testing that is not *pre-certified*, yet deemed to be a covered service, receives out-of-network level reimbursement if deemed to be a covered service. It is highly recommended that you obtain *precertification* before initiating psychological testing in order to confirm the extent of your coverage. (Guidelines for coverage of psychological testing can be found on the UBH/OptumHealth Behavioral Solutions web site.)

ENROLLEE ASSISTANCE PROGRAM

The **Enrollee Assistance Program** can help with the following types of problems:

- Breakup of a relationship
- Divorce or separation
- Becoming a step-parent
- Helping children adjust to new family members
- Death of a friend or family member
- Communication problems
- Conflicts in relationships at work
- Legal difficulties
- Financial difficulties
- Child or elder-care needs
- Aging
- Traumatic events

To use your EAP benefit, call 1-888-610-9039 (TDD: 1-800-842-9489). The procedures for *precertifying* EAP care and referral to an EAP provider are the same as for mental health and substance abuse services. You will be referred by an UBH/OptumHealth Behavioral Solutions clinician to a trained EAP provider and/or other specialized resource (e.g., attorneys, family mediators, dependent care services) in your community. The UBH/OptumHealth Behavioral Solutions clinician may recommend mental health and substance abuse services if the problem seems to require more extensive help than EAP services can provide.

LEGAL SERVICES

In addition to EAP counseling. Legal assistance is available to enrollees of the Navigator Plan. The UBH/OptumHealth Behavioral Solutions Legal Assistance services give you free and discounted confidential access to a local attorney, who will answer legal questions, prepare legal documents, and help solve legal issues. The services provide:

- Free referral to a local attorney
- Free 30 minute consultation (phone or in-person) per legal matter
- 25% discount for ongoing services
- Free online legal information, including common forms and will kits

For more information or to be connected with UBH/OptumHealth Behavioral Solutions Legal Assistance, call UBH/OptumHealth Behavioral Solutions toll free at 1-888-610-9039 (TDD 1-800-842-9489)

EMPLOYEE ASSISTANCE PROGRAM

The Commonwealth's Group Insurance Commission also offers an Employee Assistance Program to all agencies and municipalities. Managers and supervisors can receive confidential consultations and resource recommendations for dealing with employee problems such as low morale, disruptive workplace behavior, mental illness, and substance abuse.

OUT-OF-NETWORK SERVICES

Care from an *out-of-network provider* is paid at a lower level than network care. Out-of-network care is subject to *deductibles*, *copayments*, and *coinsurance*.

Benefits are paid based on *allowed charges* that are UBH/OptumHealth Behavioral Solutions reasonable and customary fees or negotiated fee maximums. If your *out-of-network provider* or facility charges more than these *allowed charges*, you may be responsible for the difference, in addition to any amount not covered by the benefit.

Out-of-network mental health and substance abuse treatment is subject to a $150 per person/$300 per family calendar year *deductible*. Calendar year *deductibles* must be met prior to inpatient *deductibles* and *cross accumulate* between all out-of-network mental health and substance abuse benefit levels.

The *out-of-pocket maximum* for out-of-network care is $3,000 per person.

The following do not count toward the *out-of-pocket maximum*:

- Out-of-network calendar year *deductibles*
- Out-of-network inpatient *deductibles*
- *Non-notification penalties*
- Cost of treatment found to not be a covered service
- Charges in excess of UBH's/OptumHealth Behavioral Solutions' *allowed charges*

All out-of-network care must be *precertified* with UBH/OptumHealth Behavioral Solutions in order to be eligible for coverage. All *out-of-network* outpatient visits in a calendar year, including mental health, substance abuse and EAP outpatient visits, medication management visits, and in-home mental health care visits, are accumulated to determine the appropriate *out-of-network* level of reimbursement. There are different levels of reimbursement for *out-of-network* outpatient visits 1-15 and visits 16 and over as described below. Also, all *out-of-network* outpatient visits after visit 15 are subject to the same *precertification* requirements as *network* benefits in order to be eligible for coverage. Charges paid by the covered person for *out-of-network* outpatient care, if determined to be a *covered* service and if *precertified* when required, do count toward the *out of pocket maximum*. If it is determined that care was not a covered service, no benefits will be paid.

OUT-OF-NETWORK BENEFITS

Outpatient Care
Outpatient visits deemed to be a covered service are paid at 80% of UBH's/OptumHealth Behavioral Solutions' *allowed charges*, up to a maximum of 15 visits per calendar year after your $150/$300 annual *deductible* is met. These initial visits do not require *precertification*. O*ut-of-network* outpatient visits after visit 15 that are subject to the same *precertification* requirements as *network* benefits and are paid at 50% of UBH's/OptumHealth Behavioral Solutions' *allowed charges* if deemed to be a covered service. Out-of-network care utilized to satisfy the annual *deductible* counts toward the 15 visit maximum. Charges paid by the covered person for outpatient out-of-network care in excess of UBH's/OptumHealth Behavioral Solutions' *allowed charges* or for sessions after 15 that are not percertified, do not count towards the *out-of-pocket maximum*.

In-Home Care
Included in outpatient care. Visits are covered at 80% for the first 15 visits per calendar year after appropriate annual *deductibles* have been met. Out-of-network outpatient visits after visit 15 that are subject to the same *precertification* requirements as *network* benefits and are paid at 50% of UBH's/OptumHealth Behavioral Solutions' *allowed charges* if deemed to be a covered service.

Intermediate Care
Intermediate care deemed to be a covered service is paid at 80%, after appropriate annual *deductible*s have been met.

Inpatient Care
Out-of-network inpatient care deemed to be a covered service for mental health care or substance abuse treatment is paid at 80% in a general hospital, psychiatric facility, or substance abuse facility.

Each admission to a hospital or facility is subject to a $150 inpatient *deductible* per person in addition to the calendar year *deductible*. Failure to *precertify* inpatient care is subject to a *non-notification penalty* of $200 if the UBH/OptumHealth Behavioral Solutions case manager determines that the care is a covered service. No benefits will be paid if it was found not to be a covered service.

Drug Testing
There is no coverage for out-of-network drug testing.

Enrollee Assistance Program
There is no coverage for *out-of-network* EAP services.

WHAT'S NOT COVERED - EXCLUSIONS

The following exclusions apply regardless of whether the services, supplies, or treatment described in this section are recommended or prescribed by the Covered Person's provider and/or the only available treatment options for the Covered Person's condition.

This Plan does not cover services, supplies or treatment relating to, arising out of, or given in connection with the following:

- Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of Mental Health Disorders (DSM).
- Prescription drugs or over the counter drugs and treatments. (Refer to your medical plan to determine whether prescription drugs are a covered benefit.)
- Services or supplies for MHSA Treatment that, in the reasonable judgment of UBH/OptumHealth Behavioral Solutions, are any of the following:
  - not consistent with the symptoms and signs of diagnosis and treatment of the behavioral disorder, psychological injury or substance abuse;
  - not consistent with prevailing national standards of clinical practice for the treatment of such conditions;
  - not consistent with prevailing professional research demonstrating that the service or supplies will have a measurable and beneficial health outcome;
  - typically do not result in outcomes demonstrably better than other available treatment alternative that are less intensive or more cost effective; or
  - not consistent with UBH's/OptumHealth Behavioral Solutions' Level of Care Guidelines or best practices as modified from time to time.

  UBH/OptumHealth Behavioral Solutions may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information.
- Unproven, Investigational or Experimental Services. Services, supplies, or treatments that are considered unproven, investigational, or experimental because they do not meet generally accepted stands of medical practice in the United States. The fact that a service, treatment, or device is the only available treatment for a particular condition will not result in it being a Covered Service if the service, treatment, or device is considered to be unproven, investigational, or experimental.
- Custodial Care except for the acute stabilization of the Covered Person and returning the Covered Person back to his or her baseline levels of individual functioning. Care is determined to be custodial when:
  - it provides a protected, controlled environment for the primary purpose of protective detention and/or providing services necessary to assure the Covered Person's competent functioning in activities of daily living; or
  - it is not expected that the care provided or psychiatric treatment alone will reduce the disorder, injury or impairment to the extent necessary for the Covered Person to function outside a structured environment. This applies to Covered Persons for whom there is little expectation of improvement in spite of any and all treatment attempts.
- Covered Persons whose repeated and volitional non-compliance with treatment recommendations result in a situation in which there can be no reasonable expectation of a successful outcome.
- Neuropsychological testing for the diagnosis of attention deficit disorder.
- Examinations or treatment, unless it otherwise qualifies as Behavioral Health Services, when:
  - required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption;
  - ordered by a court except as required by law;
  - conducted for purposes of medical research; or
  - required to obtain or maintain a license of any type.
- Herbal medicine, holistic or homeopathic care, including herbal drugs, or other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.
- Nutritional Counseling, except as prescribed for the treatment of primary eating disorders as part of a comprehensive multimodal treatment plan.
- Weight reduction or control programs (unless there is a diagnosis of morbid obesity and the program is under medical supervision), special foods, food supplements, liquid diets, diet plans or any related products or supplies.
- Services or treatment rendered by unlicensed providers, including pastoral counselors (except as required by law), or which are outside the scope of the providers' licensure.

- Personal convenience or comfort items including, but not limited to, such items as TVs, telephones, computers, beauty/barber service, exercise equipment, air purifiers or air conditioners.
- Light boxes and other equipment including durable medical equipment, whether associated with a behavioral or non-behavioral condition.
- Private duty nursing services while confined in a facility.
- Surgical procedures including but not limited to sex transformation operations.
- Smoking cessation related services and supplies.
- Travel or transportation expenses unless UBH/OptumHealth Behavioral Solutions has requested and arranged for Covered Person to be transferred by ambulance from one facility to another.
- Services performed by a provider who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.
- Services performed by a provider with the same legal residence as the Covered Person.
- Mental health and substance abuse services for which the Covered Person has no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan.
- Charges in excess of any specified Plan limitations.
- Any charges for missed appointments.
- Any charges for record processing except as required by law.
- Services Provided Under Another Plan. Services or treatment for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. This includes but is not limited to coverage required by workers' compensation, no-fault auto, or similar legislation. If coverage under workers' compensation or a similar law is optional for Covered Person because Covered Person could elect it or could have it elected for him or her, benefits will not be paid if coverage would have been available under the workers' compensation or similar law had that coverage been elected.
- Treatment or services received prior to Covered Person being eligible for coverage under the Plan or after the date the Covered Person's coverage under the Plan ends.

Group Insurance Commission Notices

Important Notice About Your Prescription Drug Coverage and Medicare

The Centers for Medicare Services requires that this NOTICE OF CREDITABLE COVERAGE be sent to you. Please read it carefully and keep it where you can find it.

Starting January 1, 2006, Medicare prescription drug coverage became available to everyone with Medicare.

This notice:

- applies to you only if you are currently Medicare-eligible or if you should become Medicare eligible within the coming year;
- provides information about your GIC-sponsored drug coverage and Medicare drug coverage to help you decide whether to enroll in one of the Medicare drug plans;
- explains your options; and
- tells you where to find more information to help you make a decision.

FOR MOST PEOPLE, THE DRUG COVERAGE YOU CURRENTLY HAVE THROUGH YOUR GIC HEALTH PLAN IS A BETTER VALUE THAN THE MEDICARE DRUG PLANS, SO YOU DO NOT NEED TO PAY FOR ADDITIONAL DRUG COVERAGE.

Medicare Drug Plans

The Medicare prescription drug benefit, also known as Medicare Part D, is offered through various health plans and other organizations. All Medicare prescription drug plans provide at least the standard level of coverage set by Medicare; some plans also offer more coverage for a higher monthly premium. In order to decide whether to join a Medicare drug plan, compare which drugs the Medicare drug plans in your area cover and their costs, and consider the following information.

- **You can continue to receive prescription drug coverage through your GIC health plan rather than joining a Medicare drug plan. Most GIC members do not need to do anything and should not enroll in a Medicare drug plan.**
- Your GIC drug coverage is part of your GIC health insurance, which pays for your health expenses as well as your prescription drugs.
- If you elect Medicare drug coverage, you will have to pay for the entire Medicare drug coverage premium.
- If you should enroll in a Medicare drug plan while you are also enrolled in Fallon Senior Plan, Harvard Pilgrim Health Care First Seniority Freedom, or Tufts Health Plan Medicare Preferred (formerly Secure Horizons), you will lose your GIC-sponsored health plan coverage under current Medicare rules.
- If you have limited income and assets, the Social Security Administration offers help paying for Medicare prescription drug coverage. Help is available online at **www.socialsecurity.gov**, or by phone at 1-800-772-1213 (TTY 1-800-325-0778).

Creditable Coverage Information

Your GIC prescription drug coverage is, on average, expected to pay out at least as much as the standard Medicare drug coverage pays. This means that your GIC coverage is "Creditable Coverage." You may need to show this notice to the Social Security Administration as proof that you have Creditable Coverage (to avoid paying a premium penalty), if you later enroll in a Medicare drug plan.

If you drop or lose your GIC coverage and do not enroll in a Medicare prescription drug plan soon after your GIC coverage ends, you could be required to pay a premium penalty for Medicare drug coverage when you do enroll. If your GIC coverage ends and you delay 63 days or longer to enroll in Medicare drug coverage, you will have to pay a premium penalty for as long as you have Medicare drug coverage. Your monthly Medicare drug premium will go up at least 1% per month for every month after May 15, 2006 (or the month of your 65th birthday, whichever is later) that you do not have creditable drug coverage. In addition, you may have to wait until the next Medicare annual enrollment period to enroll.

For more information about this notice or your prescription drug coverage options:

- Call 1-800-MEDICARE (1-800-63304227). TTY users should call 1-877-486-2048.
- Visit **www.medicare.gov**.
- Call the Group Insurance Commission at 1-617-727-2310.

Notice of Group Insurance Commission Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

By law, the GIC must protect the privacy of your personal health information. The GIC retains this type of information because you receive health benefits from the Group Insurance Commission. Under federal law, your health information (known as "protected health information" or "PHI") includes what health plan you are enrolled in and the type of health plan coverage you have. This notice explains your rights and our legal duties and privacy practices.

The GIC will abide by the terms of this notice. Should our information practices materially change, the GIC reserves the right to change the terms of this notice, and must abide by the terms of the notice currently in effect. Any new notice provisions will affect all protected health information we already maintain, as well as protected health information that we may receive in the future. We will mail revised notices to the address you have supplied, and will post the updated notice on our website **at www.mass.gov/gic**.

Required and Permitted Uses and Disclosures
We use and disclose protected health information ("PHI") in a number of ways to carry out our responsibilities. The following describes the types of uses and disclosures of PHI that federal law requires or permits the GIC to make without your authorization.

Payment activities: The GIC may use and share PHI for plan payment activities, such as paying administrative fees for health care, paying health care claims, and determining eligibility for health benefits.

Health Care Operations: The GIC may use and share PHI to operate its programs that include evaluating the quality of health care services you receive, arranging for legal and auditing services (including fraud and abuse detection), and performing analyses to reduce health care costs and improve plan performance.

Other Permitted Uses and Disclosures:
The GIC may use and share PHI as follows:

- to resolve complaints or inquiries made on your behalf (such as appeals);
- to verify agency and plan performance (such as audits);
- to communicate with you about your GIC-sponsored benefits (such as your annual benefits statement);
- for judicial and administrative proceedings (such as in response to a court order);
- for research studies that meet all privacy requirements;
- to tell you about new or changed benefits and services or health care choices.

Required Disclosures: The GIC **must** use and share your PHI when requested by you or someone who has the legal right to act for you (your Personal Representative), when requested by the United States Department of Health and Human Services to make sure your privacy is being protected, and when otherwise required by law.

Organizations that Assist Us: In connection with payment and health care operations, we may share your PHI with our third party "Business Associates" that perform activities on our behalf, for example, our Indemnity Plan administrator. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we have asked of them. These business associates will be contractually bound to safeguard the privacy of your PHI.

Except as describe above, the GIC will not use or disclose your PHI without your written authorization. You may give us written authorization to use or disclose your PHI to anyone for any purpose. You may revoke your authorization so long as you do so in writing; however, the GIC will not be able to get back your health information we have already used or shared based upon your permission.

Your rights
You have the right to:

- Ask to see and get a copy of your PHI that the GIC maintains. You must ask for this in writing. Under certain circumstances, we may deny your request. If the GIC did not create the information you seek, we will refer you to the source (e.g., your health plan administrator). The GIC may charge you to cover certain costs, such as copying and postage.
- Ask the GIC to amend your PHI if you believe that it is wrong or incomplete and the GIC agrees. You must ask for this in writing, along with a reason for your request. If the GIC denies your request to amend your PHI, you may file a written statement of disagreement to be included with your information for any future disclosures.
- Get a listing of those with whom the GIC shares your PHI. You must ask for this in writing. The list will not include health information that was": (1) collected prior to April 14, 2003; (2) given to you or your personal representative; (3) disclosed with your specific permission; (4) disclosed to pay for your health care treatment, payment, or operations; or (5) part of a limited data set for research;
- Ask the GIC to restrict certain uses and disclosures of your PHI to carry out payment and health care operations; and disclosures to family members or friends. You must ask for this in writing. Please note that the GIC will consider the request, but we are not required to agree to it and in certain cases, federal law does not permit a restriction.
- Ask the GIC to communicate with you using reasonable alternative means or at an alternative address, if contacting you at the address we have on file for you could endanger you. You must tell us in writing that you are in danger, and where to send communications.
- Receive a separate paper copy of this notice upon request. (An electronic version of this notice is on our **website at www.mass.gov/gic**.)

If you believe that your privacy rights may have been violated, you have the right to file a complaint with the GIC or the federal government. GIC complaints should be directed to: GIC Privacy Officer, P.O. Box 8747, Boston, MA 02114. Filing a complaint or exercising your rights will not affect your GIC benefits. To file a complaint with the federal government, you may contact the United States Secretary of Health and Human Services. To exercise any of the individual rights described in this notice, or if you need help understanding this notice, please call (617) 727-2310, extension 1 or TTY for the deaf and hard of hearing at (617) 227-8583.

Your HIPAA Portability Rights

If you should terminate your GIC health plan coverage, you may need to provide evidence of your prior coverage in order to enroll in another group health plan, to reduce a waiting period in another group health plan, or to get certain types of individual coverage, even if you have health problems. This notice describes certain HIPAA protections available to you under federal law when changing your health insurance coverage. If you have questions about your HIPAA rights, contact the Massachusetts Division of Insurance (617-521-7777) or the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272.

Using Certificates of Creditable Coverage to reduce pre-existing condition exclusion waiting periods. Some group health plans restrict coverage of individuals with certain medical conditions before they apply. These restrictions, known as 'pre-existing condition exclusions', apply to conditions for which medical advice, diagnosis, care or treatment was recommended or received within six months before the individual's enrollment date. (An enrollment date is the first day of coverage under the plan, or if there is a waiting period, the first day of a waiting period, usually the first day of work). Under HIPAA, pre-existing condition exclusion periods cannot last longer than 12 months after your enrollment date (18 months if you are a late enrollee). Pre-existing condition exclusion periods cannot apply to pregnancy, or to children who enrolled in health coverage within 30 days after their birth, adoption, or placement for adoption.

If your new plan imposes a pre-existing condition exclusion period, the waiting time before coverage begins must be reduced by the length of time during which you had prior 'creditable coverage'. Most health coverage, including that provided by the GIC, Medicaid, Medicare, and individual coverage, is creditable coverage. You may combine any creditable coverage you have, including your GIC coverage shown on this certificate, to reduce the length of a pre-existing condition exclusion period required by a new plan. However, if at any time you have no coverage for 63 or more days, a new plan may not have to count the coverage period you had before the break. (However, if you are on leave under the Family and Medical Leave Act (FMLA) and you drop health coverage during your leave, any days without coverage while on FMLA leave do not count towards a 63-day break in coverage).

When you have the right to specially enroll in another plan. If you lose your group health coverage, you may be able to get into another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees. In order to do so, however, you must request enrollment within 30 days of your group coverage termination. Marriage, birth, adoption, or placement for adoption can also trigger these special enrollment rights. **Therefore, should you have such a life event or your coverage end, you should request special enrollment in another plan as soon as possible if you are eligible for it.**

You have the right not to be discriminated against based on health status. A group health plan may not refuse to enroll you or your dependents based on anything related to your health, nor can the plan charge you or your dependents more for coverage, based on health factors, than the amount it charges similarly situated individuals for the coverage.

You have the right to individual coverage. If you are eligible for individual coverage, you have a right to buy certain individual health policies without being subject to a pre-existing condition exclusion period. To be an eligible individual, you must meet the following requirements:

- You have had coverage for at least 18 months without a break in coverage of 63 days or more;
- Your most recent coverage was under a group health plan (shown on this certificate);
- Your group coverage was not terminated because of fraud or nonpayment of premium;
- You are not eligible for another group health plan, Medicare, or Medicaid, and do not have any other health insurance coverage.

Therefore, if you are interested in obtaining individual coverage and you meet the criteria to be eligible, you should apply for this coverage as soon as possible to avoid forfeiting your eligibility due to a 63-day break.

Index

This index lists the major benefits and limitations of the Navigator plan. Of course, it does not list everything in this *Member Handbook*. To fully understand all benefits and limitations, a *Member* must read through this *Member Handbook* carefully.

Need to Write or Call?

Tufts Health Plan
705 Mt. Auburn Street, P.O. Box 9173
Watertown, MA 02471-9173

1-800-870-9488

For the Enrollee Assistance Program or
Mental Health or Substance Abuse treatment,
please call United Behavioral Health

1-888-610-9039

Commonwealth of Massachusetts
Group Insurance Commission

NAVIGATOR
by TUFTS Health Plan

Tufts Health Plan
705 Mt. Auburn Street
Watertown, MA 02472

For additional information,
please call 1-800-870-9488

www.tuftshealthplan.com

GIC-NAVPPO-001 Ed. 7-2008